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ABSTRACT

This is a report of hearings held in Washington, D.C., on March 10 and 12, 1980, on the Health Professions Education and Distribution Act of 1980--three bills amending Public Health Service Act, Titles VII and VIII, and the national health Service Corps Program. S. 2375 would extend assistance programs for training health professionals and the national health service corps program. S. 2144 would provide new programs for training in health professions and nursing. S. 2378 would provide grants and fellowships for health care management, provide grants for projects to encourage geographic and specialty distribution of physicians, and amend the Immigration and Nationality Act regarding alien graduates of foreign medical schools. (Copies of the bills are included.) Testimony includes statements from eleven witnesses and twenty-eight individuals and organizations/associations representing/including Association of American Medical Colleges, American Association of Colleges of Podiatric Medicine, Association of Schools and Colleges of Optometry, American Hospital Association, American Medical Association, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Dental Schools, American Nurses' Association, American Society of Allied Health Professionals, and Association of Schools of Public Health. Additional information and an appendix of thirty-five submitted statements are provided. (YLB)

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HEALTH PROFESSIONS EDUCATION AND DISTRIBUTION ACT OF 1980

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

S. 2375

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER TITLES VII AND VIII FOR TRAINING HEALTH PROFESSIONALS AND TO EXTEND THE NATIONAL HEALTH SERVICE CORPS PROGRAM

S. 2144

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE TITLES VII AND VIII OF SUCH ACT TO PROVIDE NEW PROGRAMS FOR TRAINING IN THE HEALTH PROFESSIONS AND NURSING, AND FOR OTHER PURPOSES

S. 2378

TO AMEND TITLE VII OF THE PUBLIC HEALTH SERVICE ACT TO PROVIDE GRANTS AND FELLOWSHIPS FOR HEALTH CARE MANAGEMENT, TO PROVIDE GRANTS FOR SPECIAL PROJECTS TO ENCOURAGE GEOGRAPHIC AND SPECIALTY DISTRIBUTION OF PHYSICIANS, TO AMEND THE IMMIGRATION AND NATIONALITY ACT WITH REGARD TO ALIEN GRADUATES OF FOREIGN MEDICAL SCHOOLS, AND FOR OTHER PURPOSES

MARCH 10 AND 12, 1980

Printed for the use of the Committee on Labor and Human Resources

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HEALTH PROFESSIONS EDUCATION AND DISTRIBUTION ACT OF 1980

MONDAY, MARCH 10, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 4232, Dirksen Senate Office Building. Senator Howard M. Metzenbaum presiding pro tempore.

Present: Senators Metzenbaum, Schweiker, and Javits.

Staff present: Rhonda Friedman, Robert Knouss, Robert Wenger, and Steven Grossman.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator **METZENBAUM**. Today, the Subcommittee on Health and Scientific Research will conduct its first day of hearings on S. 2375, S. 2144, and S. 2378, bills that are designed to amend titles VII and VIII of the Public Health Service Act and the national health service corps program. I am pleased to chair this hearing at the request of Senator Kennedy.

In 1963, Congress passed the first Health Professions Training Act. At that time, our country was facing a projected shortage of physicians and other health personnel, severe geographic maldistribution of health professionals, and underrepresentation of minorities in these fields.

The questions before us today are whether these initiatives have succeeded in equalizing the shortage of health professionals, what the projected needs are in the future, and what the Federal policy should be toward training health personnel.

Today we will hear from Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation of the Department of Health, Education, and Welfare, who will discuss the administration's program to address these problems, and comment on the legislation before us. We will then hear from two panels of witnesses representing the schools of medicine, osteopathy, dentistry, podiatry, optometry, pharmacy, and veterinary medicine.

Each witness will discuss the current issues in the education of their respective professionals and react to the legislation before us.

Finally, the American Hospital Association will comment on the legislation from the perspective of the educational and service roles that our Nation's hospitals fulfill in the health delivery system.

Let the record show that the sun began to shine on our committee as we got into this enlightened aspect of the program.

I want to welcome our first witnesses to this first day of hearings on this important legislation.

Senator Schweiker, you have been a leader and certainly a strong advocate in respect to many aspects of this program, and you have your own legislation on this subject.

I will be happy to hear from you.

OPENING STATEMENT OF SENATOR SCHWEIKER

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

I am pleased to be here this morning to be part of the Health Subcommittee's hearings on health professions and nurse training legislation. From the day my bill, S. 2144, was introduced, I have made every effort to urge the Senate and House toward early hearings, markups, and passage of critically needed legislation in this field. I congratulate my Senate colleagues, Mr. Kennedy and Mr. Javits, on introducing their bills last week. Now that we have their thoughtful contributions, and with the statement of the administration today, it is my hope that we can move expeditiously toward a resolution in the Senate. The hearings today and Wednesday are an important step; prompt committee action before May 15 is equally important.

In constructing S. 2144, it was my intention to balance the need for new programs with the fiscal constraints which now face all legislation. My bill is fiscally responsible, yet compassionate. It will meet our national needs, yet will withstand the inevitable cry that any new legislation is overgenerous.

S. 2144 addresses the vital issues facing our health professions schools and students and provides meaningful and realistic answers. Some of the answers are not favored by some groups. In particular, I know that each of the groups will seek a continuation of capitation-like institutional support. Unfortunately, capitation does not enjoy the support of the Carter administration and a majority of the Congress. During the last year, the Carter administration proposed a recision of $107.8 million for health professions and nursing capitation. I led the opposition to that action in the Appropriations Committee but was defeated when the appropriations chairman joined with a majority to approve a cut. Chairman Kennedy then carried the battle to the floor and was defeated in a vote of 42–55. We also know that the Carter manpower proposal, as well as the proposed budget, continues to reflect total opposition to capitation.

What are the answers proposed by S. 2144?

S. 2144 confronts the student assistance problem. What is most needed is a program that allows financially needy students to obtain funding for their entire education with interest rates and other terms that are not disruptive of their careers and which recognizes the often long periods before students can start repayment.

A program, such as health professions student loans—HPSL—which provides average loans of only $1,200, does not meet this need. The current choice between the health education assistant loan—HEAL—program at 12 percent interest and NHSC service obligations, is really no choice at all. A student faces staggering debt or indenturement. That is why S. 2144 offers a partially subsidized loan program with no strings attached. This will considerably lessen total student debts while acknowledging that students are investors in their own education and should repay out of their future earnings.

S. 2144 provides expanded special projects with bonuses for participating schools. Without question, special projects have been a valuable means for advancing national goals and for helping schools to carry out programs of interest to them. Special projects command wide support in Congress, including the Appropriations Committee. Even the administration feels special projects are worthwhile. S. 2144 continues the successful special projects, such as primary care residency training, public health education, and area health education centers. In addition, it creates a wide variety of new programs emphasizing service to practitioners in underserved areas, improved clinical education, education in health policy and economics, curriculum development, support for practicing nurses, and improvement of nursing education. Flexible institutional moneys would be available as a bonus for schools which carry out these special projects.

S. 2144 also proposes modification of existing programs for financial distress, startup, construction, loan forgiveness, and the National Health Service Corps. In addition, a new State service scholarship program is offered as a means for involving the States more deeply in solving the problems of access to health care.

My bill is designed to maximize Federal impact on the health professions and nursing students and schools, without extravagant spending or regulation. This bill authorizes for fiscal year 1981 for these programs, a mere 6 percent more than was appropriated in fiscal year 1980. Yet I am convinced that the legitimate needs of students and schools, as well as the Federal Government, are fairly and adequately met by this legislation.

My bill offers a realistic alternative to unsatisfactory programs and progressively declining appropriations. New legislation is critically necessary to forestall massive cuts in fiscal year 1981 in the support provided to health professions schools and their students. As the ranking Republican on the Labor-HEW Appropriations Subcommittee, as well as on this committee, S. 2144 represents my measured assessment of what the Health Subcommittee can promise—with some likelihood of delivering through the Appropriations Committee.

I have started a dialog on health manpower within Congress and among constituent groups. In the weeks ahead, I hope our committee will find a realistic and fiscally responsible approach that helps to meet the needs of schools and students. Not everything can be done, but I pledge my support to find the best solutions.

Senator **Metzenbaum**. Thank you very much, Senator Schweiker.

[The introductory statements and texts of S. 2375, S. 2144, and S. 2378 along with additional material supplied for the record follows:]

[From the Congressional Record—Senate, March 4, 1980]

Introductory Statement of Mr. Kennedy on S. 2375

By Mr. ROBERT C. BYRD (for Mr. KENNEDY) (for himself, Mr. WILLIAMS, Mr. JAVITS, Mr. RANDOLPH, Mr. PELL, Mr. TSONGAS, and Mr. STEWART):

S. 2375. A bill to amend the Public Health Service Act to revise and extend the programs of assistance under titles VII and VIII for training health professionals and to extend the National Health Service Corps program; to the Committee on Labor and Human Resources.

HEALTH PROFESSIONS TRAINING AND DISTRIBUTION ACT OF 1980

Mr. ROBERT C. BYRD. Mr. President, on behalf of the Senator from Massachusetts (Mr. KENNEDY) (for himself and others), I introduce and send to the desk a bill entitled the "Health Professions Training and Distribution Act of 1980."

I ask unanimous consent that a statement by Senator KENNEDY, together with the text of the bill and a section-by-section analysis be printed in the RECORD.

There being no objection, the statement and bill were ordered to be printed in the RECORD, as follows:

STATEMENT BY SENATOR KENNEDY

I am pleased to introduce a bill along with Senators Williams, Javits, Randolph, Pell, Tsongas, and Stewart, to revise and extend the programs of the Public Health Service Act for the training of health personnel and for the National Health Service Corps.

I believe that the goals of the health care system in the United States are to provide all Americans with equal access to high-quality health care at a reasonable cost, to promote good health and prevent disease, to return individuals who are acutely ill to good health, and to improve the quality of life for individuals who are chronically ill or disabled. In order to achieve these goals, we must assure that the nation has qualified health personnel who are prepared to meet the needs of the people of this nation—black or white, rich or poor, farmer or city dweller.

Over the last two decades, we have established a partnership with the nation's health professions schools and students in order to meet our needs for qualified health professionals. Working together, we have doubled the nation's capacity to train health professionals, we have encouraged a renewed interest in primary care and we have established the National Health Service Corps which now employs over 2000 health professionals who are meeting the needs of the underserved.

Although we have come a long way to solving problems that were first identified years ago, much remains to be done. Our ability to utilize fully our human resources to meet our health care needs is now being jeopardized because many low and middle income Americans can no longer afford the price of education in our health professions schools. High levels of student indebtedness will frustrate our efforts to continue to improve appropriate specialty and geographic distribution among our health professionals. And under our current system of payment for health services, these high levels of indebtedness will surely be passed along, in higher costs, to those seeking health care.

Our students are not immune to the silent thief of double-digit inflation. A student's ability to pay for education can well become an implicit admission criterion. And despite our deep and abiding concern for equal opportunity for minorities, women, and the handicapped, their representation among the health professions remains far below their representation in the population.

The problems of geographic and specialty distribution of our health professionals is not a new issue to the Congress. This country, among those that value freedom of choice, is not alone in grappling with these problems. But we must recognize that one out of every four Americans live in a medically underserved area and one out of every seven Americans live in areas where there is a critical shortage of primary care physicians. We must do better.

Our nation's nurses are essential to our ability to provide health services and are critical members of the health care team. Without them, our ability to meet the health needs of our citizens is jeopardized. In every region of the country there appears to be a shortage of nurses. The reasons may be complex. But the fact remains that the increasing intensity of health services as a result of improved health care technology and the extremely low unemployment rate for nurses has made recruitment and retention of nurses a matter of national concern. And while some estimate that 100,000 nursing positions remain unfilled today, the enrollments at our nation's nursing schools is dropping.

Last year the Surgeon General of the United States published a report on health promotion and disease prevention required by the Public Health Service Act. The report establishes goals for the decade of the 80's to improve the health status of the American people.

In doing so, the report identifies the need of our health professionals to be activists for prevention. And as we commit ourselves to creating healthy environments and to promoting healthy lifestyles, in addition to responding to the imperatives of disease, we must commit ourselves to assuring an adequate supply of health professionals in public health—in occupational and environmental health, in nutrition, in epidemiology and biostatistics, in maternal and child health, in international health.

The bill I am introducing today is intended to begin the discussion of the renewal of the health professions and National Health Service Corps programs. It offers a comprehensive approach, with strong incentives to providing increased educational opportunities to underrepresented groups, to assuring that students will not be denied an education because they do not have sufficient personal financial resources, to increasing the availability of health professionals where they are most needed and in the fields in which they are most needed, and to increasing access to health care through the National Health Service Corps.

First, the bill increases the amount of money available to students to pursue their education. While maintaining scholarship programs for exceptionally needy students, it offers three choices to students by which they may finance their education—the National Health Service Corps scholarship program; a program of private, federally-insured, market-rate loans; and a new program with substantial interest subsidies under which the obligation to repay the loan could be discharged through national service.

This new program would meet the objectives of providing students access to loan money that does not impose excessive interest expenses, and of overcoming high debt loans which will discourage students from meeting the needs of underserved populations. But the program also provides a way for the country to meet its most pressing needs for health professionals that are not being met through other programs. Our citizens would no longer have to wait the ten years it takes to establish new initiatives and reap the benefits. No longer would we have to wonder whether our projections of future needs have undershot the mark.

The bill also authorizes a new program to provide significant incentives to the health professions schools to meet national objectives. The level of support to each school would be increased if objectives related to increased representation of minority students and women, to improved geographic and specialty distribution, and to curriculum development are met. Excessive tuition increases or enrollment increases would be discouraged by a decrease in the amount of support.

Rather than capitation grants which provided the same amount to each eligible school, proportionate to enrollment, this incentive program rewards performance in areas which are tailored to the unique contributions that each type of professional school offers. Although the bill sets forth explicit criteria, I invite, and expect, discussion of the details.

The program would encourage diversity among the students selected to enter the health professions schools by providing increased support if the percent of students who are underrepresented minority groups or who are women is increased. The efforts of the schools to recruit and enroll a more diverse student body should be translated into the same diversity among its graduates and among health care providers.

The criteria address other needs which Congress has recognized—

The need for increased numbers of primary care physicians, particularly in family medicine;

The desirability of decentralizing a portion of the educational experiences into community settings as a counterbalance to the strong incentives toward subspecialization and away from primary care;

The concern that not enough emphasis is placed on education in nutrition, geriatrics, prevention and cost-containment;

The recent decline in interest among students to enter careers as clinical investigators who bridge the gap between laboratory findings and improvements in health care.

The decline in nursing school enrollments at a time when communities across the country do not have enough nurses to meet their needs.

Furthermore, the program discourages excessive tuition and enrollment increases in our nation's medical schools. We, indeed, are facing a time when the price of education may strip many students of their ability to seek a health career; but the schools are also facing exorbitant increases in uncontrollable costs, such as energy costs. The Administration has argued that by 1990 we will face an oversupply of physicians. Although the program addresses these issues, I expect a full discussion about our schools' ability to finance their programs and about our capacity to meet our future needs.

The bill I am introducing today also includes programs to support targeted needs. These special purpose grants include a new program of cooperative agreements between the federal government and those schools which have suffered financial reverses because of their strong commitments to underserved populations. Programs are authorized to assist in meeting the cost of training in family medicine, primary care, prevention; for establishment of area health education centers and training programs in underserved areas; for increasing the recruitment and retention of students from underrepresented minority groups and disadvantaged backgrounds; for the training of physician assistants and expanded function dental auxiliaries; for emphasizing nutrition, geriatrics, rehabilitation, and cost containment in the education of our health professionals; for meeting targeted needs in the education of veterinarians, optometrists, podiatrists, and pharmacists; for training professionals in public health and health administration; and for meeting special needs in the education of allied health professionals.

A separate title in the Public Health Service Act for nursing education is maintained and strengthened. Special support for increasing the enrollment of disadvantaged students in nursing schools, to overcome imbalances in the distribution of nurses and to improve the curriculum is provided. A new program to support the clinical education of nurses, including nurses in advanced training, is authorized.

Finally, the National Health Service Corps is retained and strengthened as a central part of our commitment to meeting the needs of underserved populations and those living in shortage areas.

This bill identifies the problems which we must address during the 1980s and charts the course for their solution. Its authorizations for fiscal year 1981 represent a 30 percent decrease from the fiscal year 1980 authorizations for the comparable programs.

The Subcommittee on Health and Scientific Research of the Committee on Labor and Human Resources has scheduled hearings during March. At that time, the issues of our students' ability to finance their education, our institutions' ability to finance their programs, the adequacy of the supply of health professionals, particularly nurses, the most effective ways to solve our geographic and specialty distribution problems, and the essential role of the National Health Service Corps will be explored.

I ask that this bill to amend the Public Health Service Act to revise and extend the programs of assistance under Titles VII and VIII for training health personnel and to extend the National Health Service Corps program, along with a detailed summary of the bill, be printed at this point in the RECORD.

S. 2375

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Health Professions Training and Distribution Act of 1980".

FINDINGS AND DECLARATIONS

SEC. 2. (a) The Congress makes the following findings:

(1) the goals of the health care system in the United States are to provide all Ameri-

cans with equal access to high quality health care at a reasonable cost, to promote good health and prevent disease, to return individuals who are acutely ill to good health, and to improve the quality of life for individuals who are chronically ill or disabled;

(2) achieving these goals is dependent, in part, on the availability of qualified health professionals who have been trained to meet the needs of the people to be served;

(3) the Federal Government has established, over the years, a partnership with the Nation's health professions schools and students in order to meet the Nation's needs for qualified health professionals;

(4) the Nation's ability to utilize fully its human resources to meet its health care needs is now in jeopardy because many low- and middle-income Americans can no longer afford the price of education in the health professions;

(5) high levels of student indebtedness will frustrate efforts to improve appropriate specialty and geographic distribution among health professionals;

(6) the representation of minorities and women within most health professions remains far below their representation in the population;

(7) the capacity of the Nation's health professions schools, established over the last two decades, is, in general, sufficient to meet the Nation's needs for health professionals by the end of the 1980's. However—

(A) there is a continuing need for health professionals trained in primary care, particularly physicians trained in family practice;

(B) there exists a wide disparity in the availability of physicians (including psychiatrists) and other health professionals in many urban and rural areas and over [illegible]0 million Americans live in medically underserved areas;

(C) because of the rising demand for mental health services and wide disparities in the distribution of psychiatrists, psychiatry is a medical shortage specialty;

(D) there remains, in many of our Nation's communities, a critical inability to obtain and retain nurses; and

(8) the National Health Service Corps and other programs designed to meet the needs of the underserved continue to be necessary and should be strengthened.

(b) Therefore, the Congress declares that the Federal Government's partnership with the Nation's health professions schools and students is reaffirmed so that, with Federal assistance—

(1) all Americans can be assured equal opportunities to enter a health career;

(2) all Americans can be assured equal access to qualified health professions personnel; and

(3) the health professions schools, as a national resource, can assist in accomplishing these objectives.

Sec. 3. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

Sec. 4. The amendments made by this Act shall take effect October 1, 1980.

TITLE I—HEALTH PERSONNEL TRAINING AND DISTRIBUTION

Sec. 101. (a) The title of title VII is amended to read as follows:

"TITLE VII—HEALTH PERSONNEL TRAINING AND DISTRIBUTION".

(b) Section 700 is amended to read as follows:

"GENERAL DUTIES OF SECRETARY

"Sec. 700. The Secretary shall, after consultation with appropriate public and private entities, conduct and support activities designed to—

"(1) train sufficient numbers of health personnel to meet the health care needs of the United States;

"(2) distribute health personnel, by geographic area and specialty practice, to meet the health care needs of the United States;

"(3) provide career opportunities in health care to individuals without regard to race, sex, handicap, or income background;

"(4) assure the delivery of high quality health care; and

"(5) maximize the cost-effectiveness of health personnel training and education and the delivery of health care services.".

Sec. 102. (a)(1) Section 701(7)(A)(i) is amended by striking out "health" and inserting in lieu thereof "primary".

(2) Section 701(9) is amended by adding "the Commonwealth of" before "the Northern Mariana Islands,".

(3) Section 701(10) is amended by striking out "Department of Health, Education, and Welfare" and inserting in lieu thereof "Department of Health and Human Services".

(b)(1) The heading of section 702 is amended to read as follows:

"NATIONAL ADVISORY COUNCIL ON HEALTH PERSONNEL".

(2) Section 702(a) is amended—

(A) by striking out "Professions Education" after "National Advisory Council on Health" and inserting in lieu thereof "Personnel";

(B) by striking out "twenty" after "who shall be Chairman of the Council, and" and inserting in lieu thereof "twenty-two";

(C) by striking out "twelve" in paragraph (1) thereof, and inserting in lieu thereof "thirteen";

(D) by striking out "and" after "university administration" in paragraph (1) thereof, and inserting in lieu thereof a comma;

(E) by inserting "and at least one representative from an allied health training center," after "may receive a grant under section 791," in paragraph (1) thereof; and

(F) by striking out clause (2) thereof and inserting in lieu thereof the following: "(2) three shall be full-time students enrolled in health professions schools, or interns, or residents, and".

(3) Section 702 is amended by striking out "othtr than subpart II of part G thereof)" each place it appears.

(c) section 703 is amended—

(1) by striking out "(a)" after "Sec. 703."; and

(2) by striking out subsection (b).

(d) Section 706(b) is amended by striking out "he" after "at such time and in such manner as" and inserting in lieu thereof "the Secretary".

(e) Section 707 is amended by striking out "Professions Education" after "National Advisory Council on Health" and inserting in lieu thereof "Personnel".

(f) Section 708 is amended to read as follows:

"HEALTH PERSONNEL DATA

"Sec. 708. (a) The Secretary shall undertake or support a program to collect, compile, and analyze data at least biennially, regarding health personnel in the States including physicians, nurses, dentists, pharmacists, optometrists, podiatrists, veterinarians, public health personnel, health administrators, health planners, physician assistants, expanded function dental auxiliaries, allied personnel and any other health personnel in the States designated by the Secretary to be included in the program. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional licensure status), location or locations of practice, professional specialty, practice characteristics, place and date of birth, sex, and socioeconomic background of health personnel, the impact of title VII and VIII on the training and distribution of health personnel, and such other information regarding health personnel as the Secretary may require.

"(b) In carrying out subsection (a), the Secretary shall collect available information from public or private entities. The Secretary may make grants to and enter into contracts with public and private entities for the collection of information not otherwise available.

"(c) The Secretary, in cooperation with appropriate public and private entities, shall—

"(1) analyze or provide for the analysis of health personnel data collected under this section;

"(2) conduct or provide for the conduct of—

"(A) analytic and descriptive studies of health personnel information including the need for, and supply of, health personnel; and

"(B) projections relating to such need and supply in the future compiled according to type of personnel, practice specialty, and geograhic location; and

"(3) conduct or provide for the conduct of analytic and descriptive studies of information on health students, interns, residents, and practitioners who are participaitng in continuing education and health education programs and institutions, including student financial requirements and indebtedness, institutional resources, student characteristics such as age, sex, race, and socioeconomic background, and apparent career choices such as practice specialty and geographic location.

"(d) For purposes of providing the Secretary with information under this section, each school which receives financial support under title VII or VIII shall annually report to the Secretary information, determined to be appropriate by the Secretary, respecting the students who attend such school. The Secretary may collect such additional data respecting students of the health professions as the Secretary determines to be appropriate.

"(e) The Secretary shall submit to Congress the following reports:

"(1) a comprehensive report regarding the status of health personnel according to profession, including a report regarding the analytic and descriptive studies conducted under this section. Such report shall be submitted on October 1, 1981, and biennially thereafter;

"(2) a comprehensive report regarding applicants to, and students enrolled in, programs and institutions for the training of health personnel, including in such report descriptions and analyses of student indebtedness, student need for financial assistance, financial resources to meet the needs of students, student career choices such as practice specialty and geographic location and the relationship, if any, between student indebtedness and career choices. Such report shall be submitted on March 31, 1981, and biennially thereafter;

"(3) a report on the status of health personnel teaching facilities, including an analysis of the need for new facilities and the replacement and renovation of existing facilities, estimated aggregate construction, renovation and replacement costs, and available and appropriate sources for meeting such costs in order to meet national needs for health personnel. Such report shall be submitted on May 15, 1982; and

"(4) a report on the status of minorities, women, and other underrepresented groups among health personnel and students. Such report shall be submitted on October 1, 1981 and biennially thereafter.

"(f)(1) The Secretary and each program entity shall in securing and maintaining any record of individually identifiable personal data (hereinafter in this subsection referred to as 'personal data') for purposes of this section—

"(A) inform any individual who is asked to supply personal data whether the individual is legally required, or may refuse, to supply such data and inform the individual of any specific consequences, known to the Secretary or program entity, as the case may be, of providing or not providing such data;

"(B) upon request, inform any individual if the subject of personal data secured or maintained by the Secretary or program entity, as the case may be, and make the data available to the individual in a comprehensive form;

"(C) assure that no use is made of personal data which use is not within the purposes of this section unless an informed consent has been obtained from the individual who is the subject of such data; and

"(D) upon request, inform any individual of the use being made of personal data respecting such individual and of the identity of the individuals and entities which will use the data and their relationship to the programs under this section.

"(2) Any entity which maintains a record of personal data and which receives a request from the Secretary or a program entity for such data for purposes of this section shall not transfer any such data to the Secretary or to a program entity unless the individual whose personal data is to be so transferred gives an informed consent for such transfer.

"(3)(A) Notwithstanding any other provision of law, personal data collected by the Secretary or any program entity under this section may not be made available or disclosed by the Secretary or any program entity to any person other than the individual who is the subject of such data unless (i) such person requires such data for purposes of this section, or (ii) in response to a demand for such data made by means of compulsory legal process. Any individual who is the subject of personal data made available or disclosed under clause (ii) shall be notified of the demand for such data.

"(B) Subject to all applicable laws regarding confidentiality, only the data collected by the Secretary under this section which is not personal data shall be made available to bona fide researchers and policy analysts (including the Congress) for the purposes of assisting in the conduct of studies respecting health professions personnel.

"(4) For purposes of this subsection, the term 'program entity' means any public or private entity which collects, compiles, or analyzes health professions data under a grant, contract, or other arrangement with the Secretary under this section.

"(g) In carrying out this section, the Secretary shall not be subject to the provisions of chapter 35 of title 44, United States Code.".

(g) Section 710(1) is amended by striking out "except for grants under section 770.".

(h) Part A of title VII is amended by adding the following after section 711:

"TECHNICAL ASSISTANCE

"Sec. 712. The Secretary may provide technical assistance for the purpose of carrying out any program or purpose under this title.".

Sec. 103. (a) Section 720(a)(1) is amended by adding "(other than such facilities in a hospital or outpatient facility)" after "teaching facilities".

(b) Section 720(a)(2)(A) is amended by striking out "for the training of physicians and dentists".

(c) Section 720(a)(2)(B) is amended to read as follows:

"(B) For purposes of this section, the term 'ambulatory, primary care teaching facilities' means areas dedicated for the training of students in primary care in ambulatory settings.".

(d) Section 720(b) is amended to read as follows:

"(b)(1) For payments under grants under subsection (a)(1) there is authorized to be appropriated $2,000,000 for the fiscal year ending September 30, 1981, $2,000,000 for the fiscal year ending September 30, 1982, and $2,000,000 for the fiscal year ending September 30, 1983.

"(2) For payments under grants under subsection (a)(2) there is authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $3,000,000 for the fiscal year ending September 30, 1983.".

(e) Section 721(b) is amended—

(1) by striking out "Commissioner of Education" each place it appears and inserting in lieu thereof "Secretary of Education";

(2) by striking out paragraph (2) thereof and redesignating paragraph (3) as paragraph (2);

(3) by striking out ", whether filed by a school or, in the case of an affiliated hospital or affiliated outpatient facility, by any other public or other nonprofit agency," in paragraph (2) (as redesignated by this subsection);

(4) by striking out "hospital or outpatient"" each place it appears in paragraph (2) (as redesignated by this subsection);

(5) by striking out ", as defined in section 845" in paragraph (2) (as redesignated by this subsection); and

(6) by striking out "enrollment or" in paragraph (2)(C) (as redesignated by this subsection).

(f) Section 721(c)(2) is amended—

(1) by inserting "and" at the end of subparagraph (B);

(2) by striking out "and" after "for the training for which it is being constructed" in subparagraph (C) and inserting in lieu thereof a semicolon; and

(3) by striking out subparagraph (D).

(g) Section 721(c)(3)(B) is amended—

(1) by striking out "either" after "which facilities";

(2) by striking out "substantially either its enrollment or" after "are so obsolete as to require the school to curtail"; and

(3) by striking out "(and, for purposes of this part, expansion or curtailment of capacity for continuing education shall also be considered expansion and curtailment, respectively, of training capacity)" after "training provided".

(h) Section 721(c)(4) is amended by adding "and" at the end thereof.

(i) Section 721(c) is amended—

(1) by striking out paragraph (5) and redesignating paragraphs (6) and (7) as paragraphs (5) and (6); and

(2) by amending paragraph (5) (as redesignated by this subsection) to read as follows:

"(5) in the case of an application for a project for the construction of a facility intended, at least in part, for the provision of health services, the appropriate provisions of title XV have been complied with;".

(j) The last sentence of section 721(c) is amended by striking out "Professions Education" after "National Advisory Council on Health" and inserting in lieu thereof "Personnel".

(k)(1) Section 721(d)(1)(A) is amended—

(A) by striking out "(other than a project for facilities for continuing education)" after "an existing school"; and

(B) by inserting "to the extent the Secretary determines such expansion is necessary" after "public health personnel.".

(2) Section 721(d)(1)(B) is amended by striking out "curtailment of the school's enrollment or" after "such replacement or rehabilitation to prevent".

(3) Section 721(d)(2) is amended to read as follows:

"(2) any comments submitted by the appropriate health systems agency and State health planning and development agency.".

(l) Section 721(e) is amended—

(1) by inserting "(1)" after "(e)"; and

(2) by inserting the following new paragraph at the end thereof:

"(2) In considering applications for grants under section 720(a) for the fiscal years ending September 30, 1981, and September 30, 1982, the Secretary shall give first consideration to applications submitted by medical schools for the expansion of a two-year program to a degree granting program, and by new schools that anticipate predominantly minority student enrollment.".

(m) Section 721(g)(2) is amended by striking out "section 781, 784, or 786 (relating to area health education centers, general internal medicine and general pediatrics and family medicine and the general practice of dentistry," and inserting in lieu thereof "section 780, 781, or 784,".

(n)(1) Section 722(a) is amended—

(A) by striking out "(1)" each place it appears; and

(B) by striking out paragraph (2).

(2) Section 722(b) is amended by striking out "The Secretary's reservation of any amount under this section may be amended by him." and inserting in lieu thereof "The reservation of any amount under this section may be amended by the Secretary.".

(o) Section 723 is amended—

(1) by inserting "and reduction of enrollment requirements" after "recapture of payments" in the heading thereof; and

(2) by adding the following at the end thereof:

"(c) The Secretary may, upon the request of an applicant and after consultation with the National Advisory Council on Health Personnel, reduce or eliminate any applicable enrollment requirements to be met by the grantee under construction projects funded under this title prior to October 1, 1980.".

(p) Section 724(b) is amended by striking out "he finds" after "such other regulations as" and inserting in lieu thereof "are".

(q) Section 724 is amended by adding the following new subsection at the end thereof:

"(c) With respect to loan guarantees and interest subsidies, such regulations shall not provide for enrollment increases for the purpose of establishing eligibility for loan guarantees and interest subsidies under section 726.".

(r) Section 725 is repealed.

(s) Section 726(a) is amended by striking out "September 30, 1980" after "and ending with the close of" and inserting in lieu thereof "September 30, 1983".

(t) Section 726(b) is amended—

(1) by striking out "September 30, 1980" after "with the close of" and inserting in lieu thereof "September 30, 1983"; and

(2) by inserting before the period at the end thereof "and for loan guarantees and interest subsidies first made after October 1, 1980, such amounts as are sufficient to reduce the net effective interest rate otherwise payable on such loan—

"(1) by 6 percent per annum; or

"(2) to 7 percent per annum;

whichever is less".

(u) Section 726(d)(2) is amended by striking out "he determines it to be" after "by the Secretary to the extent" and inserting in lieu thereof "it is".

(v) Section 726(e) is amended—

(1) by striking out "him to discharge his responsibilities" in paragraph (1) and inserting in lieu thereof "the discharge of responsibilities";

(2) by striking out "by him" in paragraph (1);

(3) by striking out the second sentence and inserting in lieu thereof "There are

authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund";

(4) by striking out "by him from his operations" after "property or other assets derived" and inserting in lieu thereof "from operations";

(5) by striking out "his" after "enable the Secretary to discharge" and inserting in lieu thereof "the";

(6) by striking out "by him" after "guarantees issued";

(7) by striking out "he" after "authorized by this section," and inserting in lieu thereof "the Secretary";

(8) by striking out "he" after "for that purpose" and inserting in lieu thereof "the Secretary of the Treasury"; and

(9) by striking out "him" after "other obligations acquired by" and inserting in lieu thereof "the Secretary of the Treasury".

(w) Section 736(f) is amended by striking out "under this part in such fiscal year, except that this paragraph shall not apply if the amount of grant funds obligated under this part in such fiscal year equals the sums appropriated for such fiscal year under section 720." and inserting in lieu thereof "under section 720 in such fiscal year.".

Sec. 104. (a) Section 728(a) is amended—

(1) by striking out "and" after "September 30, 1979,";

(2) by inserting ", $100,000,000 in the fiscal year ending September 30, 1981, $125,000,000 in the fiscal year ending September 30, 1982, and $150,000,000 in the fiscal year ending September 30, 1983" after "the fiscal year ending September 30, 1980"; and

(3) by striking out "1983" in the last sentence thereof and inserting in lieu thereof "1986".

(b) Section 729(a) is amended—

(1) by striking out "$10,000" and inserting in lieu thereof "$15,000";

(2) by striking out "or public health" each place it appears and inserting in lieu thereof "public health, graduate program of health administration, or an advanced training program at a collegiate school of nursing";

(3) by striking out "$7,500" and inserting in lieu thereof "$10,000";

(4) by striking out "pharmacy," each place it appears and inserting in lieu thereof "pharmacy or physician assistant or expanded function dental auxiliary training program,";

(5) by striking out "$15,000" and inserting in lieu thereof "$20,000";

(6) by striking out "he" each place it appears and inserting in lieu thereof "the Secretary";

(7) by striking out "$50,000" and inserting in lieu thereof "$60,000";

(8) by striking out "$37,500" and inserting in lieu thereof "$50,000"; and

(9) by striking out "$60,000" and inserting in lieu thereof "$80,000".

(c) Section 731(a)(1) is amended—

(1) by striking out clause (iii) and redesignating clauses (iv), (v), and (vi) as clauses (iii), (iv), and (v);

(2) by amending clause (iii) (as redesignated by this subsection) to read as follows:

"(iii) has agreed that all funds received under such loan shall be used solely for tuition, reasonable educational expenses including fees, books, and laboratory expenses, and reasonable living expenses incurred by such student;";

(3) by amending clause (iv) (as redesignated by this subsection) to read as follows:

"(iv) for the school year for which such loan is made, receives no funds under the National Health Service Corps Scholarship Program provided in section 751, the Indian Health Service Program in section 757, the Armed Forces Health Professions Scholarship Program under chapter 105 of title 10, United States Code, or the loan program in subpart II; and".

(d) Section 731(a)(2) is amended—

(1) by striking out "he was" before "not a participant in such a program" in subparagraph (B);

(2) by striking out "23" and inserting in lieu thereof "25" in subparagraph (B);

(3) by inserting "and interest" after "periodic installments of principal" in subparagraph (C);

(4) by striking out "and be paid" after "accrue" in subparagraph (C);

(5) by striking out "three" each place it appears in subparagraph (C) and inserting in lieu thereof "four"; and

(6) by striking out "or the 23-year period" and inserting in lieu thereof "but shall be included in the 25-year period" in subparagraph (C).

(e) Section 731(a)(2) is amended by redesignating paragraphs (E) and (F) as paragraphs (G) and (H).

(f) Section 731(a)(2) is amended by inserting the following new subparagraph after subparagraph (D):

"(E) offers the borrower a graduated repayment option with larger payments due later in the repayment period that meets criteria set by the Secretary;

"(F) provides, at the option of the lender, a variable interest option at the time the loan is made based on the average of the bond equivalent rates of the ninety-one-day Treasury bills auctioned for the previous quarter, plus 3 percent, such variable interest to be determined quarterly;".

(g) Section 731(b) is amended by striking out "12 percent" after "may exceed" and inserting in lieu thereof "the average of the bond equivalent rates of the ninety-one-day Treasury bills auctioned for the previous quarter plus 3 percent".

(h) Section 731(c) is amended by inserting ", except as provided in section 731(a)(2)(C)" after "the annual interest on the outstanding principal".

(i) Section 733(d) is amended—

(1) by striking out "he" after "Federal loan insurance premiums," and inserting in lieu thereof "the Secretary"; and

(2) by striking out "he is" after "pursuant to this subpart until".

(j) Section 734 is amended—

(1) by striking out "his" each place it appears in subsection (a) and inserting in lieu thereof "the";

(2) by striking out "he" after "hereunder and for that purpose" in subsection (b); and

(3) by striking out "or other obligations acquired by him" after "may at any time sell any of the notes or" and inserting in lieu thereof "other acquired obligations".

(k) Section 735(a) is amended—

(1) by striking out "him" after "and duties vested in" and inserting in lieu thereof "the Secretary";

(2) by striking out "his" after "Secretary or property under" and inserting in lieu thereof "the Secretary's";

(3) by striking out "his" after "and payment of interest, relating to" and inserting in lieu thereof "the Secretary's";

(4) by striking out "he" after "may be modified by the Secretary if" and inserting in lieu thereof "the Secretary"; and

(5) by striking out "by him" after "evidencing a loan which has been insured".

(l) Section 735(c) is repealed.

(m) Section 737(1) is amended to read as follows:

"(1) The term 'eligible institution' means, with respect to a fiscal year, a school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, or public health, a graduate program in health administration, a collegiate school of nursing providing an advanced training program, a program for the training of physician assistants or a program for the training of expanded function dental auxiliaries within the United States.".

(n) Section 737(2) is amended—

(1) by adding the following at the end thereof: "The term 'collegiate school of nursing' means a school of nursing as defined in section 853(2). The term 'program for the training of physician assistants' means a program as defined in section 721(7). The term 'program for the training of expanded function dental auxiliaries' means a program as defined in section 701(8). The term 'graduate program in health administration' means a program which meets the criteria of section 791(c)(2)(B)"; and

(2) by striking out "Commissioner of Education" each place it appears and inserting in lieu thereof "Secretary of Education".

(o) Section 738 is amended to read as follows:

"Sec. 738. The Secretary shall discharge a borrower's liability on the loan by repaying the amount owed on the loan from the fund established by section 734—

"(1) if a borrower who has received a loan dies or becomes permanently and totally disabled (as determined by the Secretary); or

"(2) if the Secretary determines that a borrower—

"(A) failed to complete the first year of studies leading to a first professional degree;

"(B) is in exceptionally needy circumstances;

"(C) is from a low-income or disadvantaged family; and

"(D) has not resumed or cannot reasonably be expected to resume the course of studies within the years following the date upon which such studies were terminated.".

(p) Section 740 is amended—

(1) by striking out "and" at the end of paragraph (2) thereof;

(2) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; and"; and

(3) by inserting the following at the end thereof:

"(4) collection of information from the borrower, lender, or eligible institution to assure compliance with the provisions of section 731.".

(q) Section 739(b) is amended to read as follows:

"(b) The Secretary shall require an eligible institution to record, and make available to the lender and to the Secretary upon request, the name, address, postgraduate destination, and other reasonable identifying information for each student of such institution who has a loan insured under this subpart.".

Sec. 105. (a) Section 741(a)(2) is amended by striking out "him" after "to entitle" and inserting in lieu thereof "the borrower".

(b) Section 741(f)(5)(B) is amended by striking out "he terminates" after "such loan cancellation until" and inserting at the end thereof "is terminated".

(c) Section 741(k) is amended by striking out "to him" after "all the outstanding loans made".

(d) Section 741(l) is amended—

(1) by striking out "to enable him" after "as a health profession student";

(2) by striking out "his determination" after "portion thereof outstanding thereon, upon" and inserting in lieu thereof "determining";

(3) by striking out "his" after "such studies leading to" in paragraph (1) and inserting in lieu thereof "the"; and

(4) by striking out "he terminated" in paragraph (4) and inserting at the end thereof "were terminated".

(e) Section 742 is amended—

(1) by striking out "and each of the two succeeding fiscal years," after "For the fiscal year ending September 30, 1981,";

(2) by inserting "senior" after "may be necessary to enable"; and

(3) by striking out "continue or" after "before October 1, 1980, to".

(f) Section 743(a) is amended—

(7) by striking out "1983" each place it appears and inserting in lieu thereof "1980"; and

(2) by inserting ", except such amounts as are needed to make loans under section 742(a)," after "under an agreement pursuant to section 7[illegible](b) by each school".

(g) Section 743(b) is amended—

(1) by striking out "1983" each place it appears and inserting in lieu thereof "1980"; and

(2) by inserting the following at the end thereof:

"The Secretary shall deposit such sums in the fund provided for in section 747F.".

Sec. 106. Title VII is amended by redesignating subparts III, IV, and V as subparts IV, V, and VI and inserting the following new subpart after subpart II:

"Subpart III—Service Contingent Loan Program

"LOAN PROGRAM

"Sec. 745. The Secretary shall enter into an agreement at the request of any school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, school of nursing, graduate program in health administration, and programs for the training of physician assistants or expanded function dental auxiliaries to establish and operate at such institution a service contingent student loan program in accordance with this subpart.

"AGREEMENTS WITH INSTITUTIONS

"Sec. 746. Each agreement between the Secretary and the requesting school entered into under section 745 shall—

"(1) provide for the submission of a request for funds by an instituton for the subsequent academic year for loans to students, the amount of the request to consist of the aggregate amount needed by the students of such institutions for loans under this subpart and no more than 5 percent of such amount to be set aside as a reserve for unexpected student needs as provided under section 747I;

"(2) provide that such funds shall be used only for loans to eligible students as described in section 747 in accordance with the terms and conditions described in section 747A and section 747B;

"(3) provide that the school enter into an agreement with each student receiving a loan under this subpart as provided in section 747B;

"(4) provide that the institution may collect from the borrower a loan origination fee or collection fees, as determined by the Secretary;

"(5) provide that upon the beginning of the repayment period, the note or evidence of obligation may, at the option of the school, be assigned to the Secretary or with the approval of the Secretary, to any other entity for collection;

"(6) provide that the institution notify students that they must enter into an agreement with the Secretary under section 747D as a condition of receipt of a loan under this subpart; and

"(7) include such other provisions as may be necessary to protect the financial interest of the United States and further the purposes of this subpart.

"ELIGIBLE STUDENTS

"Sec. 747. (a) In order to receive a loan under this subpart an individual shall—

"(1)(A) be a full-time student at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy;

"(B) be more than a half-time student at a school of nursing;

"(C) be more than a half-time student in a graduate degree program in a school of public health, a graduate program in health administration, or an advanced training program in a collegiate school of nursing; or

"(D) be a full-time student in a program for the training of physician assistants or expanded function dental auxiliaries; and

"(2)(A) be in need of the amount of the loan to pursue a course of study;

"(B) be capable, in the opinion of the institution, of maintaining good standing in such course of study;

"(C) be accepted for enrollment in the institution, or, in the case of a student already in attendance at such institution, a student in good standing; and

"(D) enter into an agreement with the Secretary under section 747D prior to receipt of such loan.

In any case in which a student fails to maintain good standing at the institution, the eligibility of such student shall be suspended, and further payments to, or on behalf of, such student shall not be made until such student regains good standing.

"(b) No student may receive a loan under this subpart for an academic year in which such student receives a loan under subpart II, or a scholarship under the National Health Service Corps Scholarship Program or the Indian Health Service Scholarship Program, or the Armed Forces Health Professions Scholarship Program under chapter 105 of title 10, United States Code. A student receiving loan funds under this subpart may receive, for the same academic year, loans under part B or part D of the Higher Education Act of 1965.

"AMOUNT OF LOAN

"Sec. 747A. (a) The amount of a loan to a student of an institution shall be the amount necessary for the student to attend the school, and such amount shall not exceed—

"(1) in the case of a student at a school of medicine, osteopathy, or dentistry, $20,000 in any one fiscal year, and $80,000 in all fiscal years;

"(2) in the case of a student at a school of veterinary medicine, optometry, and podiatry, or a program in public health, health administration, or advanced nurse training, $15,000 in any one fiscal year, and $60,000 in all fiscal years; and

"(3) in the case of a student at a school of pharmacy, or a program for the training of physician assistants or a program for the training of expanded function dental auxiliaries, or at a school of nursing other than a student in advanced training, $10,000 in any one fiscal year, and $40,000 in all fiscal years.

"(b) In determining the amount of the loan under subsection (a), the school shall take into consideration—

"(1) any special needs of the student; and

"(2) the financial resources available to the student.

"TERMS OF LOAN AGREEMENT

"Sec. 747B. An institution shall enter into an agreement with a student for a loan under this subpart. Such agreement shall—

"(1) be evidenced by note or other written instrument which provides for repayment (except as provided in section 747D) of the principal amount of the loan, together with interest thereon, over a period beginning 12 months (except as provided in section 747C) after the date on which the student is awarded the degree or diploma in the course of study for which such student received such loan, and ending at a date not more than fifteen years (except as provided in section 747C) after such date, in installments which shall not be less frequent than quarterly;

"(2) provide for acceleration of the whole, or any part, of such loan (without penalty) at the option of the borrower;

"(3) provide that the loan shall bear interest, on the unpaid balance of the loan, at the rate of 7 percent per annum in the case of a loan to a student borrower attending a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy, and at the rate of 5 percent per annum in the case of a loan to a student borrower attending a school or program of nursing, public health, health administration, or physician assistant or expanded function dental auxiliary training, except that no interest shall accrue (A) prior to the beginning date of repayment determined under paragraph (1) or (B) during any period as provided under section 747C;

"(4) unless the borrower is a minor and the note or other evidence of obligation executed by the borrower would not, under applicable law, create a binding obligation, provide that the loan shall be made without security and without endorsement;

"(5) provide that the liability to repay the loan shall be discharged upon the death of the borrower, or if the borrower becomes permanently and totally disabled as determined by the Secretary; and

"(6) contain such other terms and conditions that the Secretary deems necessary to protect the financial interests of the United States and further the purposes of this subpart.

"DEFERRAL OF REPAYMENT

"Sec. 747C. (a) No repayment of principal of, or interest on, on any loan under this subpart shall be required but interest shall accrue and be compounded (except as provided in subsection (e)) during any period in which the student borrower—

"(1) is in the first 4 years of service in the National Health Service Corps or the Indian Health Service;

"(2) is in the first 4 years of service as a member of the Armed Forces of the United States;

"(3) is in the first 4 years of service as a volunteer under the Peace Corps Act;

"(4) is in the first 5 years in an approved internship or residency, if such student borrower has completed a course of study at a school of medicine or osteopathy;

"(5) is in the first 3 years in an approved internship or residency, if such student borrower has completed a course of study at a school of dentistry or veterinary medicine;

"(6) is in the first 2 years in an approved internship or residency if such student borrower has completed a course of study at a school of optometry, podiatry, or pharmacy;

"(7) is in the first 2 years of practice in a medically underserved area; or

"(8) is in the first 3 years in a doctoral program leading to a career in biomedical or clinical investigation, or an academic career in a health profession.

"(b) Any period during which repayment is deferred under subsection (a) shall not be included in computing the fifteen-year maximum repayment period provided in paragraph (1) of section 747B.

"(c)(1) A repayment period may be interrupted without penalty for any period during which the loan does not bear interest.

"(2) The repayment of principal or interest by a student borrower may be deferred for no more than nine months, if the collecting entity determines, in accordance with criteria of the Secretary, that absent such deferral, the student borrower would default on such loan due to inability to pay.

"(3) A loan repayment installment is overdue if such payment is not received within 120 days after the date such installment is due, or, in the case of a quarterly repayment installment, if such payment is not received within 180 days after the date such installment is due.

"(d) Notwithstanding other provisions of this subpart, the total period of the loan may not exceed 30 years from the date of execution of the note or written agreement evidencing such loan to final repayment.

"(e) A loan under this subpart shall not bear interest—

"(1) while the borrower is an eligible student described in section 747;

"(2) while the borrower is participating in the first 3 years, in the aggregate, of an approved internship or residency if such borrower has completed the course of study in a school of medicine, osteopathy, dentistry, or veterinary medicine;

"(3) while the borrower is participating in the first 2 years of an approved internship or residency if such borrower has completed the course of study in a school of optometry, podiatry, or pharmacy; and

"(4) if after the borrower has received a degree from a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy, the borrower is participating in the first 3 years of a doctoral program leading to a career as a biomedical or clinical investigator or in preparation for an academic career in a health profession.

"AGREEMENT WITH SECRETARY FOR SERVICE

"Sec. 747D. (a) As a condition for entering into a loan agreement with an institution under section 747 B, the student borrower shall, at the same time, enter into an optional service agreement with the Secretary. Such agreement shall—

"(1) provide that the borrower shall be required, at the option of the Secretary, to provide one year of service in a national priority position (as defined in subsection (e)) for each year such student receives a loan under this subpart, in lieu of repayment (not to be less than 2 years);

"(2) provide that if the borrower fulfills the period of service required by the Secretary, the Secretary shall discharge such student's loan obligation;

"(3) provide that if the borrower fails to provide any required service (for any reason), the United States shall be entitled to recover from the borrower, to discharge the borrower's obligations under all agreements entered into pursuant to this subpart, an amount determined in accordance with the formula:

$$A = 3\Phi(t-s)/t$$

in which 'A' is the amount the United States is entitled to recover; 'Φ' is the sum of the amounts paid under this subpart to or on behalf of the individual and the interest on such amounts which would be payable if at the time the amounts were paid such loans were bearing interest at the maximum legal prevailing rate, as determined by the Secretary of the Treasury; 't' is the total number of months in the individual's period of obligated service; and 's' is the number of months of such period served by such student. Any amount of penalties the United States is entitled to recover under this subsection shall, within the one-year period beginning on the date of the breach of the written contract, be paid to the United States;

"(4) contain a fair summary of the rights and liabilities of an individual, including a clear explanation of the penalties to which the United States is entitled under this section in the case of the individual's breach of such agreement;

"(5) contain such other information, written in a manner calculated to be understood by the average individual applying to participate in the loan program under this subpart, as may be necessary for the individual to understand the individual's prospective service participation;

"(6) evidence the written consent of the student to participate in either voluntary service or lottery selected service as required under subsection (d);

"(7) require the borrower to keep the Secretary informed on a regular basis of the borrower's education and employment plans so that the Secretary can prepare the list required by subsection (d); and

"(8) contain such other terms and conditions that the Secretary determines necessary to further the purpose of this subpart.

"(b) Any obligation of an individual under any agreement made under this subpart for service or payment shall be cancelled upon the death of the individual.

"(c) The Secretary shall provide to a student borrower a waiver or deferral of any service obligation or monetary penalties under an agreement entered into under this section whenever fulfillment of a service obligation would be impossible, would involve extreme hardship, or would be unconscionable.

"(d)(1) The Secretary shall prepare an ongoing list of students receiving loans under this subpart and such students' education and employment plans. A student shall be eligible to be called to service only in the year for which the student would first be required to make repayment for a loan under this subpart.

"(2) Student borrowers shall be called to service in accordance with the following procedures:

"(A) On October 1 of each year, the Secretary shall compile, after consultation with appropriate public and private entities, a list of national priority positions (as defined in subsection (e)) that need to be filled by July 1 of the next year.

"(B) On October 1 of each year, the Secretary shall notify the student borrowers that the Secretary determines are eligible to provide service under paragraph (1) that they could be called to service beginning on July 1 of the next year and shall provide such student borrowers with a copy of the list compiled under subparagraph (A).

"(C) Student borrowers eligible to provide service may volunteer to fill such positions by December 31 of each year.

"(D) By January 31 of the next year, the Secretary, by lottery, shall select student borrowers to fill the unfilled positions from among the remaining eligible student borrowers.

"(e) In listing national priority positions under subsection (d)(2)(A), the Secretary shall take into consideration the needs of the National Health Service Corps, the Indian Health Service, federally supported health service programs, Federal health care facilities, the need for professionals in health manpower shortage areas designated under section 332 or a nurse shortage area designated under section 824, the needs of States for health personnel in critical shortage areas or disciplines, and other factors as determined by the Secretary.

"(f) No scholarships may be awarded under subpart V in any fiscal year in which the Secretary does not offer loans under this subpart.

"ISSUANCE OF OBLIGATIONS

"Sec. 747E. Upon receipt of the requests submitted by institutions that have entered into agreements with the Secretary under section 746, the Secretary shall determine the aggregate amount needed by each institution for the academic year beginning in the fiscal year in which such deterimnation is made. To enable the Secretary to discharge the responsibilities of this subpart, the Secretary shall issue to the Secretary of the Treasury obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary of the Treasury, except that such obligations shall not exceed $250,000,000 in the fiscal year ending September 30, 1981, $350,000,000 in the fiscal year ending September 30, 1982, and $450,000,000 in the fiscal year ending September 30, 1983. In each fiscal year there shall be available if needed, for loans to students in schools of nursing, 20 percent of such amounts issued to the Secretary of the Treasury in obligations. Such obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the months preceding the issuance of the notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations issued hereunder and for that purpose is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under that Act, as amended, are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the obligations acquired under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such obligations shall be treated as public debt transactions of the United States: *Provided, however*, That such notes to the Secretary of the Treasury shall not be included in the totals of the budget of the United States Government and shall be exempt from any general limitation imposed by statute on expenditures and net lending (budget outlays) of the United States. Sums borrowed under this section shall be deposited in the Service Contingent Loan Fund established under section 747F and redemption of such notes and obligations shall be made by the Secretary from such Fund.

"SERVICE CONTINGENT LOAN FUND

"Sec. 747F. (a) There is established in the Treasury of the United States a Service Contingent Loan Fund (hereinafter in this section referred to as the 'Fund'), which shall be available to the Secretary without fiscal year limitation, consisting of—

"(1) moneys borrowed from the Secretary of the Treasury pursuant to section 747E;

"(2) all notes, obligations, or other property delivered or assigned to the Secretary pursuant to agreements made under section 746;

"(3) all collections of principal and interest received from loans made under section 747A;

"(4) all capital and interest distributions made to the Secretary under section 743 and section 839;

"(5) all appropriations by the Congress to discharge loan obligations under subsection (c), or to meet interest insufficiencies; and

"(6) transfers from the Loan Discharge Fund established under section 747G to discharge loan obligations and interest expenses.

"(b)(1) The notes of the Secretary to the Secretary of the Treasury to obtain funds for loans under this subpart, and all other liabilities against the appropriations or assets in the Fund in connection with loan program operations shall be liabilities of the Fund.

"(2) The assets of the Fund shall be available for—

"(A) payments for loans made by institutions having an agreement with the Secretary under section 746 in amounts not to exceed the amounts in section 746;

"(B) payments in connection with the discharge of loans upon the death of a student borrower, or if a student borrower becomes permanently and totally disabled as determined by the Secretary; and

"(C) payments of costs and expenses incurred by the Secretary in connection with the administration of the Fund.

"(c) There are authorized to be appropriated to the Fund $10,000,000 in the fiscal

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year ending September 30, 1982, $10,000,000 in the fiscal year ending September 30, 1983, and thereafter such sums as the Secretary may request from time to time, to meet the insufficiencies of the Fund to make payments of interest on account of the outstanding obligations issued by the Secretary to the Secretary of the Treasury under this subpart, to discharge loans under this subpart upon the death or disability of a borrower, and to meet costs of the Secretary in connection with the administration of the Fund.

"LOAN DISCHARGE [illegible]

"Sec. 747G. The Secretary shall establish a Loan Discharge Fund (hereinafter in this section referred to as the 'Fund') to be used in connection with the discharge of loans to borrowers who are serving in national priority positions pursuant to section 747D. Penalty collections for failure to serve shall be placed in such Fund. Congress may appropriate funds to such Fund, from time to time, at the request of the Secretary. The number of student borrowers whom the Secretary first requests to provide service in lieu of repayment in any fiscal year shall be limited by the amounts in such Fund available to discharge such students' loan obligations. The Secretary shall transfer from such Fund, to the Service Contingent Loan Fund, moneys sufficient to discharge the principal and interest oblications on behalf of borrowers who have entered a national priority position under this subpart.

"PRO RATA REDUCTION OF FUNDS

"Sec. 747H. If the aggregate amount of funds determined to be needed by institutions exceeds the limit on the amount of obligations the Secretary may issue to the Secretary of the Treasury under section 747E, the maximum amount of funds to be received by each institution requesting funds shall be ratably reduced.

"SET ASIDE

"Sec. 747I. No more than 5 percent of the funds received by a school under this subpart may be set aside as a reserve to be used for unexpected student needs during the academic year. If such reserve is not expended within such fiscal year, the request for allocated funds in the following fiscal year shall be reduced by the amount remaining. Unexpended funds in such reserve shall be invested in Treasury approved market securities bearing the highest rate of interest and the proceeds of the investment shall be placed in the reserve.".

Sec. 107. (a) Section 748(b)(1) is amended—

(1) by inserting "with paragraphs (3) and (4) and" after "shall be awarded in accordance"; and

(2) by inserting "based on the need of individuals eligible for such traineeships under paragraph (3)" at the end of the last sentence thereof.

(b) Section 748(b)(3) is amended to read as follows:

"(3) Traineeships awarded under grants made under subsection (a) shall be awarded to individuals who—

"(A) are citizens or permanent residents of the United States,

"(B) have previously received a baccalaureate degree, and

"(C) are pursuing a course of study in—

"(i) health promotion or disease prevention,

"(ii) biostatistics or epidemiology,

"(iii) health administration, health planning, or health policy analysis and planning,

"(iv) environmental or occupational health,

"(v) international health,

"(vi) dietetics or nutrition, or

"(vii) maternal and child health."

(c) Section 748(b)(4) is amended to read as follows:

"(4) An individual participating in a traineeship under this section may not, for the school year for which such traineeship is awarded, receive funds under any other provision of title VII other than under this subpart or subpart I of this part."

(d) Section 748(c) is amended—

(1) by striking out "and" after "September 30, 1979,"; and

(2) by inserting ", $9,000,000 for the fiscal year ending September 30, 1981, $10,000,000 for the fiscal year ending September 30, 1982, and $11,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

(e) Section 749(a) is amended by inserting "who are citizens or permanent residents of the United States" after "train students".

(f) Section 749(b)(1) is amended by inserting ", based upon the need of students attending such program who are citizens or permanent residents of the United States" after "shall be determined by the Secretary".

(g) Section 749(b)(3) is amended to read as follows:

"(3) In awarding traineeships under this section, each applicant shall assure to the satisfaction of the Secretary that the funds received under this section shall be awarded for traineeships to individuals who have received a baccalaureate degree. No student may participate in a traineeship under this section in any school year in which such individual is also receiving funds under any other provision of title VII except funds received under this subpart or subpart I of this part.".

(h) Section 749(c) is amended—

(1) by striking out "and" after "September 30, 1979,"; and

(2) by inserting ", $4,000,000 for the fiscal year ending September 30, 1981, $4,500,000 for the fiscal year ending September 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

Sec. 108. (a)(1) Section 751(d) is amended—

(A) by striking out "and" at the end of paragraph (1) thereof; and

(B) by striking out paragraph (2) and inserting in lieu thereof the following:

"(2) second to applications made (and contracts submitted) by individuals who have received one or more loans under subpart III, or who are participating in their first year of training; and

"(3) third to applications made (and contracts submitted) by all other individuals eligible to apply.".

(2) Section 751(d) is amended by adding the following at the end thereof: "In the case of awards to students in schools of medicine and osteopathy submitting applications as described in paragraphs (2) and (3), the Secretary shall set aside 80 percent of such awards for the purpose of providing scholarships to eligible applicants at schools of medicine and osteopathy in each State proportionate to the need for physicians to provide services in health manpower shortage areas in the State. If the number of applicants attending schools in a State is less than the proportionate need for physicians in health manpower shortage areas in the State, the remaining awards set aside under this subsection may be made to any qualified medical or osteopathic student applicant in any State.".

(b) Section 751(e)(1) is amended by inserting the following at the end thereof: "The Secretary shall approve or disapprove the individual's application submitted under subsection (b)(3), and contracts submitted under subsection (b)(4) no later than August 1 of each year.".

(c) Section 751(e)(2) is amended by inserting the following at the end thereof: "The Secretary shall promptly notify the educational institution at which the individual is accepted for enrollment or is enrolled under subsection (b)(1) when such individual applies to participate in the Scholarship Program, and when the contract submitted by such individual is approved by the Secretary.".

(d) Section 751(g)(1) is amended by striking out "or under section 758 (relating to scholarships for first-year students of exceptional financial need)," after "under the Scholarship Program".

(e) Section 751(j) is amended to read as follows:

"(j) The administrative unit which administers parts E and F of this title shall—

"(1) develop regulations, funding priorities, and application forms, and

"(2) make recommendations to the Secretary in the review of applications for scholarships and grants,

with respect to the Scholarship Program.

(f)(1) Section 752(b)(1) is amended by striking out "his" after "the full-time clinical practice of" and inserting in lieu thereof "the individual's".

(2) Section 752(b)(4) is amended by striking out "his" after "the full-time clinical practice of" and inserting in lieu thereof "the individual's".

(3) Section 752(b)(5)(B) is amended by striking out "his" after "the individual completes".

(4) Section 752(d) is amended by striking out "his" after "such individual to serve" and inserting in lieu thereof "the".

(5) Section 752(e) is amended by striking out "his" after "such individual to perform" and inserting in lieu thereof "the".

(g)(1) The heading of section 753 is amended to read as follows:

"INDEPENDENT PRACTICE"

(2) Section 753(a) is amended—

(A) by striking out "shall" each place it appears and inserting in lieu thereof "may";

(B) by inserting after "section 752(a)" the following: "or under section 225 as in effect prior to October 1, 1977";

(C) by striking out "private clinical practice" and inserting in lieu thereof "independent practice";

(D) by striking out "(A)" after "(designated under section 332) which" in paragraph (2);

(E) by striking out ", and" after "under section 333(c)" and inserting in lieu thereof a period in paragraph (2);

(F) by striking out clause (B) in paragraph (2); and

(G) by striking out the last sentence thereof (h) Section 753(b) is amended—

(1) by striking out "private practice" in paragraph (1) and inserting in lieu thereof "independent practice";

(2) by adding at the end of paragraph (1) the following new subparagraph:

"(C) The individual, in providing health care services covered by part A or part B of title XVIII of the Social Security Act, shall agree to accept assignment and to accept the reasonable charge as payment in full, and"; and

(3) by redesignating paragraph (2) as paragraph (3) and inserting the following new paragraph after paragraph (1):

"(2) provide for the submission of periodic reports as required by the Secretary;".

(i) Section 753 is amended by adding at the end thereof the following new subsections:

"(c) The Secretary shall provide to each individual released from service obligation under this section technical assistance to assist such individual in fulfilling his or her agreement under this section.

"(d) Failure to meet the terms of the agreement under subsection (b) shall be considered a breach of the scholarship contract as provided in section 754.

"(e) The Secretary shall, out of appropriations authorized under section 338, pay to individuals participating in independent practice under this section, up to—

"(1) $10,000 in the first year;

"(2) $7,500 in the second year;

"(3) $5,000 in the third year; and

"(4) $2,500 in the fourth year;

of obligation service, or the difference between such individual's net income before taxes and such individual's income as a member of the Corps, whichever is less, and the cost of such individual's malpractice insurance.".

(j) Section 754(a) is amended by striking out "he" after "the educational institution in which" and inserting in lieu thereof "the individual".

(k) Section 754(b) is amended—

(1) by striking out "he" after "the educational institution in which" and inserting in lieu thereof "the student";

(2) by striking out "he" after "in such an educational institution for which" in paragraph (2) and inserting in lieu thereof "the individual"; and

(3) by striking out "to him, or on his behalf," after "for the amount which has been paid" and insering in lieu thereof "to or on behalf of, the individual".

(l) Section 754(c) is amended—

(1) by striking out "his" after "an individual breaches" and inserting in lieu thereof "the"; and

(2) by striking out "him" after "such period served by" and inserting in lieu thereof "the individual".

(m) Section 755(a) is amended by striking out "(other than an individual who has entered into an agreement under section 753)".

(n) Section 756(a) is amended—

(1) by striking out "and" after "September 30, 1979,";

(2) by inserting ", $95,000,000 for the fiscal year ending September 30, 1981, $105,000,000 for the fiscal year ending September 30, 1982, and $115,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980";

(3) by striking out "1981" in the second sentence thereof and inserting in lieu thereof "1984"; and

(4) by striking out "1980" in the second sentence thereof and inserting in lieu thereof "1983".

(o) Section 756(b) is amended to read as follows:

"(b) Of the sums appropriated under this section, no less than 80 percent shall be obligated for scholarships for medical and osteopathic students.".

Sec. 109. (a) Section 758(b)(2) is amended by striking out "the scholarship described in section 751(g)" after "under subsection (a) shall be" and inserting in lieu thereof "the lesser of (A) tuition and fees plus $[illegible] or (B) $5,000".

(b) Section 758(c) is amended by inserting "based on the proportionate enrollment of first-year students who are in exceptional financial need, after "among all schools of the health professions".

(c) Section 758(d) is amended—

(1) by striking out "and" after "September 30, 1979,"; and

(2) by inserting ", $10,000,000 for the fiscal year ending September 30, 1981, $11,000,000 for fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

(d) Section 759 is repealed.

(e) Part C of title VII is amended by adding the following new subpart at the end thereof:

"Subpart VII—Repayment

"Sec. 759. (a) In the case of any individual—

"(1) who has received a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, doctor of optometry or an equivalent degree, bachelor of science in pharmacy or an equivalent degree, or doctor of podiatry or an equivalent degree, or has graduated from a graduate program in public health or health administration, or has received a diploma or degree from a school of nursing, or has graduated from a program for the training of physician assistants or expanded function dental auxiliaries;

"(2) who (A) obtained one or more loans under this part, or (B) obtained, under a written loan agreement, any other educational loan for the costs of attending a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, or podiatry, or nursing, or a graduate program in public health or health administration, or a program for the training of physician assistants or expanded function dental auxiliaries; and

"(3) who enters into an agreement with the Secretary to practice such individual's profession (as a member of the National Health Service Corps or otherwise) for a period of at least two years in a health manpower shortage area designated under section 332 or a nurse shortage area designated under section 836 in a State; the Secretary shall make payments in accordance with subsection (b), for and on behalf of such individual, on the principal and interest on any loan described in paragraph (2) which is outstanding on the date the borrower begins the practice specified in the agreement described in paragraph (3) of this paragraph.

"(b) The payments described in subsection (a) shall be made by the Secretary as follows:

"(1) Upon completion by the individual for whom the payments are to be made of the first year of the practice specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 15 percent of the principal of, and the interest on, each loan of such individual described in subsection (a)(2) which is outstanding on the date the borrower began such practice.

"(2) Upon completion by the individual of the second or third year of such practice, the Secretary shall pay 20 percent of the principal of, and the interest on each such loan in each such year.

"(3) Upon completion by the individual of a fourth year of such practice, the Secretary shall pay 25 percent of the principal of, and the interest on each such loan.

No payment may be made under this subsection with respect to a loan described in subsection (a)(2)(B) unless the person on whose behalf the payment is to be made has submitted to the Secretary a certified copy of the agreement under which such loan was made.

"(c) Notwithstanding the requirement of completion of practice specified in subsection (b), the Secretary shall, on or before the due date thereof, pay any loan or loan installment which may fall due within the period of practice for which the borrower may receive payments under this subsection, upon the declaration of such borrower, at such times and in such manner as the Secretary may prescribe (and supported by such other evidence as the Secretary may reasonably require), that the borrower is then engaged as described by subsection (a), and that the borrower will continue to be so engaged for the period required (in the absence of this subsection) to entitle the borrower to have made the payments provided by this subsection for such period, except that not more than 85 percent of the principal of any such loan shall be paid pursuant to this subsection.

"(d) A borrower who fails to fulfill an agreement with the Secretary entered into under subsection (a) shall be liable to reimburse the Secretary for any payments made pursuant to subsection (b) or (c) in consideration of such agreement.

"(e) In the case of an individual who received a loan under this part or under title VIII prior to October 1, 1980, for which the Secretary may make payments for or on behalf of such individual pursuant to a provision other than this section, such student may select the repayment provision that provides the terms for payment by the Secretary most favorable to the student.".

Sec. 110. Part E of title VII is amended to read as follows:

"PART E—GRANTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, OSTEOPATHY, DENTISTRY, VETERINARY MEDICINE, OPTOMETRY, PHARMACY, PODIATRY, AND PUBLIC HEALTH

"NATIONAL PRIORITY INCENTIVE GRANTS

"Sec. 771. (a) The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and public health to support the educational programs of such schools and projects and activities that are in the national interest.

"(b) The Secretary shall not make a grant under this section to any school in a fiscal year unless the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, or public health, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.

"(c)(1) New schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and public health that—

"(A) have governing bodies of which a majority are comprised of individuals from underrepresented minority groups; or

"(B) will enroll in the first year students a majority of whom will be from underrepresented minority groups,

shall be eligible to receive grants under this part in the year preceding the year in which the school enrolls its first students, based on an estimate of its first-year enrollment.

"(2) New schools of podiatry shall be eligible to receive grants under this part in the year preceding the year in which the school enrolls its first students, based on an estimate of its first-year enrollment.

"Sec. 772. (a) The amount of any grant in any fiscal year under section 771 shall be the amount as provided in this section per full-time student enrolled in such school multiplied by the number of full-time students enrolled (or in the case of schools of public health, the number of full-time and full-time equivalents of part-time students). In addition to such amount, schools described in section 771(c) that will have at least 24 students enrolled in the first-year class shall each receive an additional $100,000.

"(b) Notwithstanding subsection (a), if the aggregate of the amounts of the grants to be made in accordance with such subsection for any fiscal year to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health with approved applications exceeds the total of the amounts appropriated for such category of schools under the appropriate provision of section 774 for such grants, the amount of a school's grant with respect to which such excess exists shall for such fiscal year be an amount which bears the same ratio to the amount determined for the school under subsection (a) as the appropriate provision of section 774 for grants to schools of the same category bears to the amount required to make grants in accordance with subsection (a) to each of the schools of such category with approved applications.

"(c)(1) Each school of medicine shall receive $500 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $550 for each full-time student in the fiscal year ending September 30, 1982, and $600 for each full-time student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) Fifteen percent or more of the first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C)(i) Twenty percent or more of the graduating students or twenty percent or more of the total number of students graduating in the year in which the grant application is made and the previous year enter approved family practice residences, or (ii) the ratio of the number of third-year residents in approved family practice internal medicine or pediatrics residencies of the school and affiliated with the school, less the number of such residents in the previous year who entered any subspecialty fellowship program, to the total number of third-year residents in all approved residencies of the school and affiliated with the school, is no less than 0.5.

"(D) Fifteen percent or more of the first-year students at the school are from health manpower shortage areas designated under section 332 and the school conducts ten percent or more of all undergraduate clinical education for its students in community-based, primary care settings remote from the school, including health maintenance organizations, area health education centers, home care programs, community health centers, hospices, and other comparable settings.

"(E)(i) All fourth-year students have had, or will have before graduation, substantial education in at least two of the following areas: nutrition, geriatrics, prevention (including occupational medicine), health care economics (including cost containment), or rehabilitation, or

"(ii) The school undertakes activities that will substantially (as determined by the Secretary) increase the number of students who will pursue careers in clinical investigation.

"(3) The amount in paragraph (1) shall decrease in each fiscal year by an amount equal to 0.25 times such amount in paragraph (1) for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) The tuition charged by the school is greater than the tuition for such school as determined under section 711.

"(B) The first-year enrollment of the school is greater than 2 percent in excess of the enrollment in the previous year. The Secretary may waive the limit provided in this subparagraph if an additional increase will increase educational opportunity for underrepresented minority groups or for women, or for other reasons as determined by the Secretary.

"(d)(1) Each school of osteopathy shall receive $500 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $550 for each full-time student in the fiscal year ending September 30, 1982, and $600 for each full-time student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) Fifteen percent or more of the first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C) The school has a program for the training of faculty for primary care education, or has expanded an existing such program, in which at least ten individuals, who otherwise would not be prepared to assume a faculty role, will, during the year, obtain such preparation.

"(D) All full-time students who graduate will have no less than six weeks of clinical training in areas which are geographically remote from the main site of the training facilities of the school or in which medically underserved populations reside.

"(E) All fourth-year students have had, or will have before graduation, substantial education in at least two of the following areas: nutrition, geriatrics, prevention (including occupational medicine), health care economics (including cost containment), or rehabilitation.

"(3) The amount in paragraph (1) shall decrease in each fiscal year by an amount equal to 0.25 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) The tuition charged by the school is greater than the tuition for such school as determined under section 711.

"(B) The first-year enrollment of the school is greater than 2 percent in excess of the enrollment in the previous year. The Secretary may waive the limit provided in this subparagraph if the increase will increase educational opportunities for underrepresented minority groups or for women, or for other reasons as determined by the Secretary.

"(e)(1) Each school of dentistry shall receive $500 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $550 for each full-time student in the fiscal year ending September 30, 1982, and $600 for each full-time student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) Fifteen percent or more of the first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C)(i) Ninety percent of the graduates of the school enter the general practice of dentistry or become residents in general practice dentistry, pedodontics or public health; or

"(ii) Seventy percent of the new first-year positions in dental specialty programs at the school established after September 30, 1979, are in public health, general practice, or pedodontics, provided that at least six new first-year positions have been established since September 30, 1979.

"(D) Ten percent or more of the first-year full-time students are from health manpower shortage areas designated under section 332, and all full-time students who graduate will have at least six weeks of clinical training in areas which are geographically remote from the school or in which medically underserved populations reside.

"(E) All fourth-year students have had, or will have before graduation, substantial education in two of the following areas: dental care to the elderly, preventive or community dentistry, nutrition, or health care economics (including cost containment).

"(3) The amount in paragraph (1) shall decrease in each fiscal year by an amount equal to 0.25 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) The tuition charged by the school is greater than the tuition for such school as determined under section 711.

"(B) The first-year enrollment of the school is greater than 2 percent in excess of the enrollment in the previous year. The Secretary may waive the limit provided in this subparagraph if the increase will increase educational opportunities for underrepresented minority groups or for women, or for other reasons as determined by the Secretary.

"(f)(1) Each school of veterinary medicine shall receive $300 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $330 for each full-time student in the fiscal year ending September 30, 1982, and $360 for each full-time student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria which are met by the school in the year in which a grant application is made:

"(A)(i) The school increases its first-year enrollment of full-time students from underrepresented minority groups by twenty-five percent or ten students, whichever is greater, over the preceding year, or

"(ii) Fifteen percent or more of the first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C) Thirty percent or more of the first-year full-time students are residents of States which do not have schools of veterinary medicine.

"(D) The clinical training of the school has primary emphasis on care for food-producing animals, fiber-producing animals, or both.

"(g)(1) Each school of optometry shall receive $150 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $165 for each full-time student in the fiscal year ending September 30, 1982, and $180 for each student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria which are met by the school in the year in which a grant application is made:

"(A)(i) The school increases its first-year enrollment of full-time students from underrepresented minority groups by twenty-five percent or ten students, whichever is greater, over the preceding year, or

"(ii) Fifteen percent or more of first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C)(i) The first-year enrollment of the school is no less than the first-year enrollment on September 30, 1978; or meets the requirements of section 771(g)(2) as in effect prior to October 1, 1980, whichever is greater.

"(ii) Twenty-five percent (or fifty percent if the school is a nonprofit private school of optometry) or more of the first-year full-time students are residents of States which do not have accredited schools of optometry.

"(D) All fourth-year students have had, or will have before graduation, substantial clinical educational experience in developmental, rehabilitative, or geriatric optometry, or at least a six-week clinical, educational experience in an ambulatory care setting geographically remote from the school or in a medically underserved area.

"(h)(1) Each school of podiatry shall receive $200 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $220 for each full-time student in the fiscal year ending September 30, 1982, and $240 for each full-time stu[illegible] the fiscal year ending September 30, [illegible]

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria which are met by the school in the year in which a grant application is made:

"(A)(i) The school increases its first-year enrollment of full-time students from underrepresented minority groups by twenty-five percent or ten students, whichever is greater, over the preceding year, or

"(ii) Fifteen percent or more of first-year full-time students are from underrepresented minority groups.

"(B) Forty percent or more of the first-year full-time students are women.

"(C)(i) The first-year enrollment of the school is no less than the first-year enrollment on September 30, 1978, or meets the requirement of section 771(g)(3) as in effect prior to October 1, 1980, whichever is greater.

"(ii) Forty percent or more of the first-year full-time students are residents of States which do not have accredited schools of podiatry.

"(D) All fourth-year students have had, or will have before graduation, substantial clinical educational experience in meeting the foot care needs of the elderly or in an ambulatory care setting.

"(i)(1) Each school of pharmacy shall receive $140 for each full-time student enrolled at the school in the fiscal year ending September 30, 1981, $155 for each full-time student in the fiscal year ending September 30, 1982, and $170 for each full-time student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A)(i) The school increases its first-year enrollment of full-time students from underrepresented minority groups by twenty-five percent or ten students, whichever is greater, over the preceding year; or

"(ii) Fifteen pecent or more of first-year full-time students are from underrepresented minority groups.

"(B) All fourth-year students have received or will receive prior to graduation a training program described in section 771(1) as in effect prior to October 1, 1980.

"(C) All fourth-year students have had, or will have had before graduation, substantial education in two of the following areas: geriatrics, nutrition, prevention, mental health care, or health care economics (including cost containment).

"(j)(1) Each school of public health shall receive $500 for each full-time and full time-equivalent student enrolled at the school in the fiscal year ending September 30, 1981, $550 for each full-time and full-time-equivalent student in the fiscal year ending September 30, 1982, and $600 for each full-time and full-time-equivalent student in the fiscal year ending September 30, 1983.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A) Fifteen percent or more of the full-time and full-time-equivalent students who are initially enrolled are from underrepresented minority groups.

"(B)(i) Seventy percent or more of the full-time and full-time-equivalent students are pursuing a course of study in epidemiology, biostatistics, health, administration, nutrition, international health, occupational health, or environmental health, or

"(ii) The percent of such students in (I) epidemiology and biostatistics, (II) health administration, or (III) occupational [illegible]ronmental health, exceed twenty percent, thirty percent, or twenty percent, respectively.

"(C) Fifty percent or more of the students receiving graduate degrees will enter public service or will utilize the skills obtained in areas designated by the Secretary as needing such personnel.

"(3) The amount in paragraph (1) shall decrease in each fiscal year by an amount equal to 0.25 times such amount for each of the following criteria which are met by the school in the year in which the grant application is made:

"(A) The tuition charged by the school is greater than the tuition for such school as determined under section 711.

"(B) The initial enrollment of full-time and full-time-equivalent students is less than such enrollment in the previous year.

"(k) A reference to a year is reference to an academic year unless otherwise specifically identified.

"ENROLLMENT DETERMINATIONS

"Sec. 773. (a) For purposes of this section, regulations of the Secretary shall include provisions relating to the determination of the number of students enrolled in a school or in a particular year-class in a school on the basis of estimates of the number of students who in an earlier year were enrolled in a school or in a particular year-class, or on such other basis as the Secretary deems appropriate for making such determination, and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

"(b)(1) For purposes of this part, the term 'full-time student' (whether such term is used by itself or in connection with a particular year-class) means a student pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, doctor of optometry or an equivalent degree, doctor of podiatry or an equivalent degree, bachelor or master of science in pharmacy or an equivalent degree, or to a graduate degree in public health or equivalent degree.

"(2) In the case of a training program of a school designed to permit the students enrolled in such program to complete, within 6 years after completing secondary school, the requirements for a degree of doctor of medicine, doctor of osteopathy, or doctor of dentistry or an equivalent degree, the term 'full-time student' shall only include a student enrolled on a full-time basis in the last 4 years of such program, and a student enrolled in the first of the last 4 years of such program shall be considered a first-year student.

"(3) For purposes of this section, the term 'full-time student' when applied to a student in a school of pharmacy, shall only include a student enrolled on a full-time basis in the last 4 years of such program. A student enrolled in the first of the last 4 years of such program shall be considered a first-year student, and a student enrolled in the last of the last 4 years shall be considered a fourth-year student.

"(c) For purposes of this part, the number of full-time equivalents of part-time students for a school of public health for any school year is a number equal to—

"(1) the total number of credit hours of instruction in such year for which part-time students of such school, who are pursuing a course of study leading to a graduate degree in public health or an equivalent degree, have enrolled, divided by;

"(2) the greater of—

"(A) the number of credit hours of instruction that a full-time student of such school was required to take in such year, or

"(B) 9;

rounded to the next highest whole number.

"(d) For purposes of computing the amount of any grant under this part, the number of full-time students at a school where more than fifty percent of the students enrolled are from underrepresented minority groups shall be tripled, and the amount of such grant shall be paid to such school prior to any proration of funds under section 772(b).

"AUTHORIZATION OF APPROPRIATIONS

"Sec. 774. (a) There are authorized to be appropriated $69,000,000 in the fiscal year ending September 30, 1981, $76,000,000 in the fiscal year ending September 30, 1982, and $84,000,000 in the fiscal year ending September 30, 1983, for payments under grants under this part to schools of medicine.

"(b) There are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, $5,500,000 for the fiscal year ending September 30, 1982, and $6,100,000 for the fiscal year ending September 30, 1983, for payments under grants under this part for schools of osteopathy.

"(c) There are authorized to be appropriated $23,000,000 for the fiscal year ending September 30, 1981, $24,200,000 for the fiscal year ending September 30, 1982, and $26,000,000 for the fiscal year ending September 30, 1983, for payments under grants under this part for schools of dentistry.

"(d) There are authorized to be appropriated $4,800,000 for the fiscal year ending September 30, 1981, $5,000,000 for the fiscal year ending September 30, 1982, and $5,500,000 for the fiscal year ending September 30, 1983, for payments under grants under this part to schools of veterinary medicine.

"(e) There are authorized to be appropriated $1,400,000 for the fiscal year ending September 30, 1981, $1,600,000 for the fiscal year ending September 30, 1982, $1,800,000 for the fiscal year ending September 30, 1983, for payments under grants under this part to schools of optometry.

"(f) There are authorized to be appropriated $[illegible]300,000 for the fiscal year ending September 30, 1981, $1,400,000 for the fiscal year ending September 30, 1982, and $1,600,000 for the fiscal year ending September 30, 1983, for payments under grants under this part to schools of pharmacy.

"(g) There are authorized to be appropriated $7,200,000 for the fiscal year ending September 30, 1981, $7,900,000 for the fiscal year ending September 30, 1982, and $8,700,000 for the fiscal year ending September 30, 1983, for payments under grants under this part to schools of pharmacy.

"(h) There are authorized to be appropriated $9,000,000 for the fiscal year ending September 30, 1981, $9,900,000 for the fiscal year ending September 30, 1982, and $11,000,000 for the fiscal year ending September 30, 1983, for payments under grants under this part to schools of public health.

"APPLICATIONS FOR GRANTS

"Sec. 775. (a) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under section 771 for any fiscal year shall be filed.

"(b) To be eligible for a grant under section 771, the applicant shall—

"(1) be a public or other nonprofit school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, and

"(2) be accredited by a recognized body or bodies approved for such purpose by the Secretary of Education. The requirement of paragraph (2) shall be deemed to be satisfied if (A) in the case of a school which by reason of an insufficient period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Secretary of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Secretary makes a final determination as to approval of the application, or (B) in the case of any other school, the Secretary of Education finds after such consultation and after consultation with the Secretary that there is reasonable ground to expect that, with the aid of a grant (or grants) under this part, having regard for the purposes of the grant for which application is made, such school will meet such accreditation standards within a reasonable time.

"(c) The Secretary shall not approve or disapprove any application for a grant under section 771 except after consultation with the National Advisory Council on Health Personnel.

"(d) A grant under section 771 may be made only if the application therefor—

"(1) is approved by the Secretary;

"(2) contains such additional information as the Secretary may require to make the determinations under the section authorizing the grant for which the application is made, and such assurances as are necessary to carry out the purposes of such section; and

"(3) provides for such fiscal control and accounting procedures and reports, including the use of standard procedures for the recording and reporting of financial information, as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to ensure proper disbursement of, and accounting for, funds paid to the applicant under such grant.

"(e) For purposes of administering the requirements of section 772, a reference to a year-class of students is a reference to students enrolled in such class for the first time, except that a student who, for other than academic reasons, withdraws from a year-class before the end of an academic year or does not complete an academic year shall not be considered as having been enrolled in a year-class in such academic year.".

Sec. 111. (a) Part F of title VII is amended by inserting the following: after the heading "Part F—Grants and Contracts for Programs and Projects":

"Subpart I—Special Programs".

(b) Section 780 is amended to read as follows:

"PROJECT GRANTS FOR FAMILY MEDICINE

"Sec. 780. (a) The Secretary may make grants to, or enter into contracts with, schools of medicine or osteopathy or appropriate public or nonprofit private entities, including hospitals, to—

"(1) plan, develop, and operate, or maintain training programs in family medicine for students of medicine or osteopathy, giving special consideration to the establishment or operation of academic administrative units (which may be departments, divisions, or other units) to provide instruction in family medicine;

"(2) plan, develop, and operate, or maintain approved internship (including internships in osteopathic medicine) or residency training programs in family medicine;

"(3) plan, develop, and operate, or maintain programs for the training of physicians who plan to teach in family medicine training programs; or

"(4) plan, develop, and operate, or maintain a program for continuing education in the field of family medicine for practicing physicians.

"(b) Grants and contracts under this section may include financial assistance to students of medicine or osteopathy, interns, residents, and physicians who are participants in programs under paragraph (1), (2), or (3) of subsection (a). Prior to awarding grants or entering into contracts under this section, the Secretary shall receive satisfactory assurances that interns and residents plan to practice family medicine, and physicians receiving funds under subsection (a)(3) plan to teach in family medicine training programs.

"(c) There are authorized to be appropriated for grants and contracts under this section $63,000,000 for the fiscal year ending September 30, 1981, $70,000,000 for the fiscal year ending September 30, 1982, and $77,000,000 for the fiscal year ending September 30, 1983. No less than 10 percent of the funds appropriated in each fiscal year shall be for grants or contracts awarded under paragraph (3) of subsection (a).".

(c) Section 781(f) is amended—

(1) by inserting "(1)" after "(f)"; and

(2) by inserting the following new paragraph at the end thereof:

"(2) The Secretary shall give priority under this section to applicants whose proposed area to be served is an entire State.".

(d) Section 781(g) is amended—

(1) by striking out "and" after "September 30, 1979,"; and

(2) by inserting ", $25,000,000 for the fiscal year ending September 30, 1981, $27,000,000 for the fiscal year ending September 30, 1982, and $29,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

(e) Section 783 is amended to read as follows:

"PROGRAMS FOR PHYSICIAN ASSISTANTS

"Sec. 783. (a) The Secretary may make grants to or enter into contracts with schools of medicine or osteopathy or appropriate public or nonprofit private entities (1) to meet the costs of projects to plan, develop, and operate or maintain programs for the training of physician assistants (as defined in section 701(7)), or (2) to establish traineeships for physician assistants, participating in such training programs.

"(b) No grant or contract may be made or entered into under subsection (a) unless the Secretary receives satisfactory assurances that the school or entity has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted in positions for which they have been trained.

"(c) The costs of a grant or contract under this section may include the costs of preparing faculty members to teach in programs for the training of physician assistants.

"(d) In order to participate in a traineeship under this section, a trainee shall enter into an agreement with the Secretary providing that such trainee shall practice for a reasonable period of time as a physician assistant in a health manpower shortage area, or in a hospital in which more than 50 percent of the interns or residents on January 10, 1977 were alien graduates of foreign medical schools.

"(e) There are authorized to be appropriated for grants and contracts under this section $10,000,000 for the fiscal year ending September 30, 1981, $11,000,000 for the fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983.".

(f) Section 784 is amended to read as follows:

"GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS IN PRIMARY CARE INTERNAL MEDICINE AND PRIMARY CARE PEDIATRICS

"Sec. 784. (a) The Secretary may make grants to or enter into contracts with schools of medicine or osteopathy, or appropriate public or nonprofit private entities, including hospitals to meet the costs of projects to—

"(1) plan, develop, and operate, or maintain approved residency training programs in internal medicine or pediatrics, that emphasize the training of residents for the practice of primary care internal medicine or primary care pediatrics;

"(2) plan, develop, and operate, or maintain programs for the training of physicians who plan to teach in primary care internal medicine or primary care pediatrics;

"(3) provide financial assistance to residents who are participants in a residency program described in paragraph (1), and who plan to specialize or work in the practice of primary care internal medicine or primary care pediatrics; or

"(4) provide financial assistance for physicians to teach primary care internal medicine or pediatrics.

"(b) There are authorized to be appropriated to carry out the provisions of this section $25,000,000 for the fiscal year ending September 30, 1981, $26,000,000 for the fiscal year ending September 30, 1982, and $27,000,000 for the fiscal year ending September 30, 1983.".

(g) Section 785 is amended to read as follows:

"DENTAL EDUCATION

"Sec. 785. (a) The Secretary may make grants to or enter into contracts with schools of dentistry or appropriate public or nonprofit private entities to meet the costs of projects to—

"(1) plan, develop, and operate or maintain programs for the training of expanded function dental auxiliaries (as defined in section 701(8));

"(2) plan, develop, and operate, or maintain a program to train dental students in the organization and management of multiple auxiliary dental team practice;

"(3) plan, develop, and operate, or maintain an approved residency program in the general practice of dentistry; and

"(4) provide financial assistance to residents in any residency program in the general practice of dentistry who plan to practice general dentistry.

"(b) No grant or contract may be made or entered into under subsection (a)(1) unless the Secretary receives satisfactory assurance that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted in positions for which they have been trained.

"(c) The costs of a grant or contract under this section may include costs of preparing faculty members to teach in programs for the training of expanded function dental auxiliaries or for the training of residents in the general practice of dentistry.

"(d) There are authorized to be appropriated for grants and contracts under this section $6,000,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30, 1982, and

$10,000,000 for the fiscal year ending September 30, 1983.".

(h) Section 787 is amended to read as follows:

"EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM UNDERREPRESENTED MINORITY GROUPS AND DISADVANTAGED BACKGROUNDS

"SEC. 787. (a) For the purpose of assisting individuals from underrepresented minority groups or disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary), to undertake education to enter a health profession, the Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health, training centers for the allied health professions, graduate programs in health administration, or other public or private nonprofit health or educational entities, to assist in meeting the costs of—

"(1) establishing secondary education programs designed to increase the number of students from underrepresented minority groups or disadvantaged backgrounds that pursue careers in the health professions;

"(2) strengthening the preprofessional curriculum of baccalaureate degree institutions predominantly attended by individuals from underrepresented minority groups or disadvantaged backgrounds;

"(3) establishing joint programs between baccalaureate degree institutions and health professions schools, training centers, or other appropriate entities designed to increase the number of students from underrepresented minority groups or disadvantaged backgrounds in health professions schools;

"(4) providing, for a period prior to the entry of such individuals into the regular course of education of health professions schools, preliminary education designed to assist such individuals in successfully completing such regular course of education at such schools, or referring such individuals to institutions providing such preliminary education;

"(5) identifying, recruiting, and selecting individuals from underrepresented minority groups or disadvantaged backgrounds, for education and training in a health profession;

"(6) facilitating the entry of such individuals into such schools;

"(7) providing counseling or other services designed to assist such individuals to complete successfully their education at such schools;

"(8) publicizing existing sources of financial aid available to students in the education program of such school or who are undertaking training necessary to qualify to enroll in such program; or

"(9) increasing the number of faculty from underrepresented minority groups or disadvantaged backgrounds in the health professions schools.

"(b)(1) There are authorized to be appropriated for grants and contracts under this section $30,000,000 for the fiscal year ending September 30, 1981, $33,000,000 for the fiscal year ending September 30, 1982, and $36,000,000 for the fiscal year ending September 30, 1983. No less than 75 percent of funds appropriated in each fiscal year shall be for grants or contracts to institutions of higher education.

"(2) Funds provided under grants and contracts under this section may be used to provide traineeships to students in programs under subsection (a)(4) if such students would not otherwise be able to participate.".

(i) Section 788(a) is amended by inserting the following new paragraph at the end thereof:

"(6) There are authorized to be appropriated to carry out the purposes of this subsection such sums as may be necessary to meet the costs of projects supported under this subsection prior to October 1, 1980.".

(j) Section 788(b) is amended to read as follows:

"(b)(1) The Secretary may make grants to, or enter into contracts with, schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing, or public health for the purposes of assisting in—

"(A) meeting the costs of operation of any such school if such school's financial status threatens its continued operation; and

"(B) meeting accreditation requirements.

"(2)(A) The Secretary may enter into cooperative agreements for not more than five years with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing, or public health that are national priority institutions (as defined in subparagraph (C)) to provide financial assistance to such institutions to meet incurred or prospective costs of operation essential to remove such institution from serious and longstanding financial instability.

"(B) Funds received under this paragraph may be used to pay short-term and long-term debts of such schools, meet accreditation requirements, maintain the quality of an academic program, strengthen academic resources or meet other necessary costs.

"(C) The term 'national priority institution' means a health education institution—

"(i) that has a predominant enrollment of individuals from underrepresented minority groups or disadvantaged backgrounds;

"(ii) the graduates of which predominantly serve medically underserved populations; or

"(iii) the affiliated hospitals, clinics, and other health facilities of which predominantly serve medically underserved populations.

"(3) Any grant awarded, contract entered into, or cooperative agreement under this subsection may be made under such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree to—

"(A) disclose any financial information or data deemed by the Secretary to be necessary to determine the source or causes of such school's financial distress;

"(B) conduct a comprehensive cost analysis study in cooperation with the Secretary; and

"(C) develop and carry out appropriate operational, managerial, and financial reforms to stabilize its operation or meet its accreditation requirements within a reasonable period of time.

"(4)(A) A school shall not be eligible to receive a grant or enter into a contract under paragraph (1) if such school or entity has received a grant or contract in each of the preceding 3 years under paragraph (1), or under section 788(b) (as such section was in effect prior to October 1, 1980).

"(B) A school may not receive a grant or enter into a contract under paragraphs (1) and (2) in any one fiscal year.

"(5) The Secretary may provide to any school eligible for a grant, contract or cooperative agreement under this subsection technical assistance to enable the school to comply with the requirements under paragraph (3).

"(6)(A) There are authorized to be appropriated for grants and contracts under this subsection $15,000,000 for the fiscal year ending September 30, 1981, $20,000,000 for the fiscal year ending September 30, 1982, $20,000,000 for the fiscal year ending September 30, 1983, and $20,000,000 for each of the following two fiscal years.

"(B) If the funds appropriated in any fiscal year to carry out this subsection are insufficient to carry out cooperative agreements entered into in any previous fiscal year under paragraph (2), no funds shall be available for grants and contracts under paragraph (1).

"(C) Funds provided under this paragraph shall remain available until expended without regard to any fiscal year limitation.".

(k) Subsections (c), (d), (e), (f), and (g) of section 788 are repealed.

(l) Section 790(1) is amended by striking out "Professions Education" after "National Advisory Council on Health" and inserting in lieu thereof "Personnel".

(m) Part F of title VII is amended by adding at the end thereof the following new subpart:

"Subpart II—SPECIAL PROJECTS

"PROJECTS TO MEET NEEDS OF MEDICALLY UNDERSERVED POPULATIONS

"SEC. 791. (a) The Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy or appropriate public or nonprofit entities to meet costs of projects to—

"(1) develop new admissions policies, procedures, and criteria to increase the enrollment of students who are committed to serve medically underserved populations, who are residents of medically underserved areas or who are likely to enter primary care practice;

"(2) plan, develop, and operate, or maintain clinical education programs (or parts thereof) including preceptorships and interdisciplinary training in medically underserved areas or in health manpower shortage areas; or

"(3) plan, develop, and operate, or maintain programs, to provide individuals who plan to meet or are meeting the needs of medically underserved populations, education (including continuing education) and training related to the delivery of health care to medically underserved populations.

"(b) There are authorized to be appropriated for grants and contracts under this section $5,000,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30, 1982, and $8,000,000 for the fiscal year ending September 30, 1983.

"CONVERSION PROJECTS

"SEC. 792. (a)(1) The Secretary may make a single grant to any private two-year school of medicine (or any school accredited as such a two-year school) to assist such school in converting to a school accredited to grant the degree of doctor of medicine. The amount of such grant shall be equal to the product of $50,0000 and the number of third-year students that will be initially enrolled in such school.

"(2) Upon request of a school, a grant received under this section may be used in the year preceding the initial enrollment of third-year students in such school.

"(b) No grant may be made under this subsection unless—

"(1) an application therefor has been submitted to the Secretary no later than September 30, 1981;

"(2) the school enrolls third-year students not later than the school year beginning in the fiscal year ending September 30, 1982; and

"(3) the Secretary receives satisfactory assurances that the school will be affiliated with an accredited hospital in the fiscal year for which such grant is made.

"PREVENTIVE MEDICINE OR DENTISTRY

"SEC. 793. (a) The Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, or dentistry to meet the costs of projects to—

"(1) plan, develop, and operate, or maintain training programs in preventive or community medicine (including occupational medicine) or dentistry for medical or dental students;

"(2) plan, develop, and operate, or maintain academic administrative units (including departments, divisions, or other units) in the field of preventive or community medicine (including occupational medicine) or dentistry;

"(3) plan, develop, and operate, or maintain joint programs between faculties in the field of preventive or community medicine (including occupational medicine) or dentistry and other clinical faculties for the purpose of improving the knowledge and skills of students, interns, residents, practicing physicians or dentists who specialize or plan to specialize in other clinical fields, particularly the field of primary care;

"(4) plan, develop, and operate, or maintain continuing education programs in preventive or community medicine (including occupational medicine) or dentistry; or

"(5) plan, develop, and operate, or maintain programs to train faculty in the fields of preventive or community medicine (including occupational medicine) or dentistry.

"(b) The Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, public health, or appropriate public or nonprofit private entity to meet the costs of projects to—

"(1) plan, develop, and operate, or maintain approved residency training programs in preventive medicine (including occupational medicine) or dentistry; or

"(2) provide financial assistance to residents who plan to specialize in the field of preventive medicine or dentistry.

"(c) There are authorized to be appropriated for grants and contracts under this section $6,000,000 for the fiscal year ending September 30, 1981, $7,000,000 for the fiscal year ending September 30, 1982, and $8,000,000 for the fiscal year ending September 30, 1983.

"PROJECT GRANTS FOR OPTOMETRY, PHARMACY, PODIATRY, AND VETERINARY MEDICINE

"Sec. 794. (a) The Secretary may make grants to or enter into contracts with—

"(1) schools of optometry to meet the costs of planning, developing, and operating, or improving—

"(A) didactic or clinical education, including continuing education, in developmental, rehabilitative, geriatric, or preventive vision care, or pharmacology and the prescription and use of pharmaceuticals (consistent with applicable State laws),

"(B) clinical education for students at practice sites that serve medically underserved populations, and

"(C) cooperative educational programs with schools of medicine or osteopathy, including the affiliation of schools of optometry with academic health centers, designed to conduct interdisciplinary training or enhance the clinical or didactic education offered by the schools of optometry;

"(2) schools of pharmacy to meet the costs of planning, developing, operating, or improving—

"(A) didactic or clinical education, including continuing education, in clinical pharmacy or clinical pharmacology (including the clinical portion of residency training programs), or in pharmacokinetics or clinical pharmacokinetics,

"(B) clinical education for students at practice sites that serve medically underserved populations,

"(C) didactic or clinical education in specialized pharmacy practice areas including health education and prevention, primary, geriatric, pediatric, and mental health care in both inpatient and ambulatory practice sites, and

"(D) interdisciplinary programs designed to prepare health professionals in the delivery of services by patient care teams;

"(3) schools of podiatry to meet the costs of planning, developing, and operating, or improving—

"(A) cooperative educational programs with schools of medicine or osteopathy, or hospitals, including the affiliation of schools of podiatry with academic health centers, designed to conduct interdisciplinary training or enhance the clinical or didactic education offered by schools of podiatry,

"(B) podiatric educational resources in geographic areas in need of such resources, including decentralized education programs,

"(C) programs to increase the enrollment of existing schools of podiatry,

"(D) residency training and continuing education programs in podiatric medicine, and

"(E) didactic or clinical education, including continuing education, in the prevention of disorders and diseases of the foot, the detection of incipient disorders and diseases of the foot, and the recovery of foot function to regain or improve mobility, particularly among the elderly; or

"(4) schools of veterinary medicine to meet the costs of planning, developing, and operating, or improving—

"(A) didactic or clinical education, including continuing education, in veterinary medicine, including public health and toxicology, pathology, the care of laboratory animals, the development and use of animal protein to meet nutritional needs, and the study of aquatic animals to improve the quantity and safety of catches for human consumption, or

"(B) clinical education in the care of food and fiber producing animals, including clinical education at practice sites remote from such schools.

"(b) Funds received under this section may be used for the development of faculty for the programs supported under subsection (a).

"(c) There are authorized to be appropriated for grants and contracts under this section $9,000,000 for the fiscal year ending September 30, 1981, $10,000,000 for the fiscal year ending September 30, 1982, and $11,000,000 for the fiscal year ending September 30, 1983.

"SPECIAL PROJECTS IN NUTRITION, GERIATRICS, REHABILITATION, AND THE CONTAINMENT OF HEALTH CARE COSTS

"Sec. 795. (a) The Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy, or appropriate public or nonprofit private entities to meet the costs of projects to—

"(1) improve—

"(A) the education of students, interns, or residents in nutrition;

"(B) the relationship of nutrition to health, human development, and illness,

"(C) the evaluation of nutritional status,

"(D) the provision of nutritional counseling, and

"(E) the use of nutritional therapies in the treatment of human disease;

"(2) improve the education of students, interns, or residents in the provision of health care to the elderly through—

"(A)(i) didactic or clinical education in aging and the health problems of the elderly,

"(ii) the use of drugs and other therapeutic modalities in the care of the elderly (including the manifestations of adverse drug actions and interactions), and

"(iii) the unique requirements for the delivery of health care to the elderly, or

"(B) interdisciplinary projects emphasizing the team approach to geriatric care;

"(3) improve the education of students, interns, or residents in the rehabilitation of disabled individuals, emphasizing the restoration, to the maximum extent possible, of functional abilities, or

"(4) improve the education of students, interns, or residents in the economics of health care, and the application of cost-containment methods in the delivery of health care without diminishing the quality of such care.

"(b) There are authorized to be appropriated for grants and contracts under this section $8,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, and $10,000,000 for the fiscal year ending September 30, 1983.

"PROJECTS FOR WOMEN IN HEALTH

"Sec. 796. (a) The Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry, or appropriate public or nonprofit private entities to meet the costs of projects to increase the participation of women in health careers and to encourage the advancement of women by—

"(1) assisting counselors and advisers in preprofessional schools to provide information to women about courses of study and access to professional careers in health;

"(2) providing information to women about sources of student financial assistance;

"(3) increasing the enrollment of women in courses of study that are prerequisite to entrance into health professions schools;

"(4) increasing the representation of women among faculties in health professions educational institutions; and

"(5) providing courses or programs designed to assist women health professionals who have interrupted their practice to reenter the active practice of their professions.

"(b) There are authorized to be appropriated for grants and contracts under this section $2,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983.

"RESEARCH AND DEMONSTRATION PROJECTS

"Sec. 797. (a) The Secretary may make grants to or enter into contracts with appropriate public or nonprofit private entities to meet the costs of projects to—

"(1) improve the education (including continuing education) of health personnel through the research, development, demonstration, application, and validation of innovative educational techniques, materials, courses, and curricula;

"(2) enhance the evaluation and self-evaluation of the competency of health personnel, including the establishment of new or improved methods or systems for awarding credentials to health professionals; and

"(3) develop, implement, and evaluate new approaches to attracting and retaining health personnel in locations in need of such professionals and in professions and specialties in need of personnel.

"(b) There are authorized to be appropriated for grants and contracts under this section $2,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983.".

Sec. 113. (a) The heading of part G of title VII is amended by inserting "Public Health," after "Programs for Personnel in".

(b)(1) Sections 791, 792, 795, and 796 are redesignated as sections 798, 799, 799A, and 799B, respectively.

(2) Sections 793, 797, and 798 (as in effect prior to October 1, 1980) are repealed.

(c) Section 799(c)(2) (as redesignated by this section) is amended to read as follows:

"(2) The Secretary may not approve an application submitted under paragraph (1) unless—

"(A) such application contains assurances satisfactory to the Secretary that in the school year (as defined in regulations by the Secretary) beginning in the fiscal year for which the applicant receives a grant under subsection (a) that—

"(i) at least tweny-five individuals will complete the graduate educational programs of the entity for which such application is submitted; and

"(ii) such entity shall expend or obligate at least $125,000 in funds from non-Federal sources to conduct such programs; and

"(B)(i) such application contains assurances satisfactory to the Secretary that the number of first-year full-time students enrolled in such programs shall be increased in each school year beginning with the school year beginning in the fiscal year ending September 30, 1981, in excess of the number of full-time first-year students enrolled in such programs in the school year beginning in the fiscal year ending September 30, 1979, by—

"(I) 5 percent of such number if such number was not more than 100, or

"(II) 2.5 percent of such number or 5 students, whichever is greater, if such number was more than 100; or

"(ii) such an application contains assurances satisfactory to the Secretary that such entity shall maintain the first year enrollment in such programs at the level of such enrollment in the school year beginning in the fiscal year ending September 30, 1980, and, submit and have approved, a plan whereby the program will emphasize, in the curriculum and special courses, cost-containment and other mechanisms available to health planners, and administrators, and managers designed to maximize cost-efficiency in the delivery of health care, such plan to be implemented in the first year of a grant and a report on the progress of such plan to be included in each subsequent application under this subsection;

"(C) such application contains such other information as the Secretary may prescribe; and

"(D) the program for which such application was submitted has been accredited for the training of individuals for health administration, hospital administration, or health planning by a recognized body or bodies approved for such purpose by the Secretary of Education and meets such other quality standards as the Secretary shall by regulation prescribe.".

(d) Section 709(c) (as redesignated by this section) is amended by striking out paragraph (3) and redesignating paragraph (4) as paragraph (3).

(e) Section 709(c)(3) (as redesignated by this section is amended by striking out "Professions Education" after "National Advisory Council on Health" and inserting in lieu thereof "Personnel".

(f) Section 709(d) (as redesignated by this section) is amended—

(1) by striking out "and" after "September 30, 1979"; and

(2) by inserting ", $4,000,000 for the fiscal year ending September 30, 1981, $4,500,000 for the fiscal year ending September 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

(g) Section 709 (as redesignated by this section) is amended to read as follows:

"SPECIAL PROJECTS FOR ACCREDITED SCHOOLS OF PUBLIC HEALTH AND GRADUATE PROGRAMS IN HEALTH ADMINISTRATION

"Sec. 709. (a) The Secretary may make grants to or enter into contracts with accredited schools of public health or graduate programs in health administration that meet the requirements of section 708(c)(3)(D) to meet the costs of special projects to develop new programs or to expand existing programs in—

"(1) disease prevention and health promotion;

"(2) biostatistics on epidemiology;

"(3) health administration, health planning, health policy analysis and planning, or cost-containment;

"(4) environmental or occupational health;

"(5) dietetics and nutrition; or

"(6) maternal and child health.

"(b) Costs of projects for which funds may be received under this section may include the costs of—

"(1) continuing education;

"(2) part-time programs for advanced training of practicing professionals in need of new knowledge or skills; or

"(3) other retraining and midcareer leadership programs.

"(c) The Secretary shall consult with the National Advisory Council on Health Personnel prior to awarding grants or entering into contracts under this section.

"(d) There are authorized to be appropriated for grants and contracts under this section $6,000,000 for the fiscal year ending September 30, 1981, $7,000,000 for the fiscal year ending September 30, 1982, and $8,000,000 for the fiscal year ending September 30, 1983.".

(h) Section 709A(2)(D) (as redesignated by this section) is amended by striking out "Commissioner" after "for such purpose by the" and inserting in lieu thereof "Secretary".

(i) Section 709B(a) is amended—

(1) by inserting "planning," after "State systems for the" in paragraph (1);

(2) by striking out "and nurses" after "allied health personnel" in paragraph (1) in each place it appears; and

(3) by inserting "and for the identification of the requirements for allied health personnel," after "and their clinical affiliates" in paragraph (1).

(j) Section 709B(a)(3) (as redesignated by this section) is amended by striking out "new roles and functions for allied health personnel and".

(k) Section 709B(a)(5) (as redesignated by this section) is amended by inserting ", including such programs designed to prepare allied health personnel to teach or serve in administrative or supervisory positions" after "allied health personnel".

(l) Section 709B(a) (as redesignated by this section) is amended by inserting the following at the end thereof:

"(7) Establishment or improvement of programs to increase clinical competency in special areas, subjects, or functions, particularly long-term care, hospice care, disease prevention, health promotion, and the application of new technologies.".

(m) Section 709B(b) (as redesignated by this section) is amended by inserting the following at the end thereof:

"(3) The Secretary shall consult with the National Advisory Council on Health Personnel prior to awarding a grant or entering into a contract under this section.".

(n) Section 709B(d)(1) is amended—

(1) by striking out "and" after "September 30, 1979,"; and

(2) by inserting ", $10,000,000 for the fiscal year ending September 30, 1981, $11,000,000 for the fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

TITLE II—NURSE EDUCATION AMENDMENTS

Sec. 201. This title may be cited as the "Nurse Education Amendments of 1980".

Sec. 202. (a) The heading of part A of title VIII is amended to read as follows:

"Part A—Assistance for Nurse Education".

(b) Section 801 is amended—

(1) by striking out "and" after "fiscal year 1979,"; and

(2) by inserting ", $1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983" after "September 30, 1980".

(c) Section 802(b) is amended by striking out "his determination" after "approved by the Secretary upon" and inserting in lieu thereof "determining".

(d) The second sentence of section 803(b) is amended—

(1) by striking out "Secretary's"; and

(2) by striking out "by him" and inserting in lieu thereof "by the Secretary".

(e) Section 805 is amended—

(1) by striking out "1980" each place it appears in subsections (a) and (b) thereof and inserting in lieu thereof "1983";

(2) by striking out "by not to exceed 3 per centum per annum" in subsection (b) thereof;

(3) by inserting "by the lesser of 3 percent per annum or such percentage per annum necessary to reduce such net effective interest rate to 7 percent for loan guarantees and interest subsidies first made after October 1, 1980" after "otherwise payable on such loan" at the end of subsection (b);

(4) by striking out "he" each place it appears in subsections (c) and (d) and inserting in lieu thereof "the Secretary";

(5) by striking out "to enable him to discharge his responsibilities" in subsection (e) and inserting in lieu thereof "to enable the discharge of the Secretary's responsibilities";

(6) by striking out "by him" in subsection (e);

(7) by striking out the second sentence of subsection (e) and inserting in lieu thereof the following: "There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund.";

(8) by striking out "derived by him from his operations" in subsection (e) thereof and inserting in lieu thereof "derived from the operations";

(9) by striking out "the Secretary to discharge his responsibilities" in subsection (e) thereof and inserting in lieu thereof "the discharge of the Secretary's responsibilities";

(10) by striking out "by him" in the fourth sentence of subsection (e) thereof;

(11) by striking out "he" in the fourth sentence of subsection (e) thereof and inserting in lieu thereof "the Secretary";

(12) by striking out "he" in the fifth sentence of subsection (e) thereof;

(13) by striking out "him" in the sixth sentence of subsection (e) thereof and inserting in lieu thereof "the Secretary of the Treasury";

(14) by striking out "this subpart" after "funds obligated under" in subsection (f) thereof and inserting in lieu thereof "section 801"; and

(15) by striking out ", except that this paragraph shall not apply if the amount of grant funds so obligated in such fiscal year equals the sum appropriated for such fiscal year under section 801".

Sec. 203. Subpart II of part A of title VIII is amended to read as follows:

"Subpart II—Incentive Grants

"NATIONAL PRIORITY INCENTIVE GRANTS

"Sec. 810. (a) The Secretary shall make annual grants to schools of nursing to support the education programs of such schools and other projects and activities that are in the national interest.

"(b)(1) For purposes of this part, regulations of the Secretary shall include provisions relating to determination of the number of students enrolled in a school, or in a particular year-class in a school, or the number of graduates, on the basis of estimates or on the basis of the number of students who were enrolled in a school, or in a particular year-class in a school, or were graduated, in an earlier year, or on such basis as the Secretary deems appropriate for making such determination, and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

"(2) For purposes of this part, the term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study in an accredited program in a school of nursing.

"(c) For purposes of computing grants under this subpart the enrollment of a school shall be—

"(1) in the case of a collegiate school of nursing, the number of full-time and full-time equivalent of part-time undergraduate students of such school enrolled in the last two years in a fiscal year;

"(2) in the case of an associate degree school of nursing, the number of full-time students of such school in the first year divided by two, and the number of full-time students of such school in the last year in a fiscal year; and

"(3) in the case of a diploma school of nursing, the number of full-time students of such school in a fiscal year.

"(d) If the total of the grants to be made under this section for any fiscal year to schools with approved applications exceeds the amount appropriated under subsection (i) for such grants, the amount of the grant for such fiscal year to each such school shall be ratably reduced.

"(e) The amount of a grant to a school under this section shall be the amount as provided in subsection (h) multiplied by the enrollment of such school (as determined under subsection (d)).

"(f) The Secretary shall not make a grant under this section to any school of nursing in any fiscal year unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that the school will expend in carrying out its function as a school of nursing, during the fiscal year for which funding is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the average amount of the funds expended by such school for such purposes (excluding expenditures of a nonrecurring nature) in the three fiscal years immediately preceding the fiscal year for which such grant is sought.

"(g) The amount of a grant to a school under this section shall be determined as follows:

"(1)(A) A collegiate school of nursing shall receive $150 for the fiscal year ending September 30, 1981, for each enrolled student as determined under subsection (c)(1), $165 for the fiscal year ending September 30, 1982, for each such enrolled student, and $180 for the fiscal year ending September 30, 1983, for each such enrolled student.

"(B) An associate degree school of nursing shall receive $100 for the fiscal year ending September 30, 1981, for each enrolled student as determined under subsection (c)(2), $110 for the fiscal year ending September 30, 1982, for each such enrolled student, and $120 for the fiscal year ending September 30, 1983, for each such enrolled student.

"(C) A diploma school of nursing shall receive $100 for the fiscal year ending September 30, 1981, for each enrolled student as determined under subsection (c)(3), $110 for the fiscal year ending September 30, 1982, for each such enrolled student, and $120 for the fiscal year ending September 30, 1983, for each such enrolled student.

"(2) The amount in paragraph (1) shall increase in each fiscal year by an amount equal to 0.5 times such amount for each of the following criteria that are met by the school in the year in which a grant application is made:

"(A)(i) The number of students enrolled in the final year of training at the school is greater than the number of such students in the previous year; or (ii) the number of students graduating is greater than the number of students that graduated in the previous year.

"(B) Twenty-five percent of the graduates of the school in the preceding year are employed as nurses in a State or portion of a State which has a lower ratio of employed nurses to the population than three-quarters of all States, as determined by the Secretary.

"(C) No less than 15 percent of the students entering a collegiate school of nursing are students who have successfully completed training in an associate degree or diploma school of nursing and who have enrolled in the collegiate school to complete the program offered by such school.

"(D) No less than 15 percent of the entering class are from underrepresented minority groups, and the school has a program designed to recruit, retain and graduate such individuals.

"(3) The amount in paragraph (1) shall decrease in each fiscal year by an amount equal to 0.25 times such amount if, in the year in which a grant application is made, the number of entering students is less than the preceding year.

"(4) The amount under paragraph (1) shall not be increased by more than 1.5 times such amount under paragraph (2) for any school receiving a grant under this section in any fiscal year.

"(5) A reference to a year is a reference to a school year unless otherwise stated.

"(h) There are authorized to be appropriated for grants under this section $30,000,000 for the fiscal year ending September 30, 1981, $33,000,000 for the fiscal year ending September 30, 1982, and $35,000,000 for the fiscal year ending September 30, 1983.

"APPLICATION FOR GRANTS

"Sec. 811. (a) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications under this subpart for any fiscal year must be filed.

"(b) The Secretary shall not approve or disapprove any application for a grant under this subpart except after consultation with the National Advisory Council on Nurse Training.

"(c) A grant under this subpart may be made only if the application therefor—

"(1) is from a public or nonprofit private school of nursing;

"(2) contains such additional information as the Secretary may require to make the determinations required under this subpart and such assurances as the Secretary may find necessary to carry out the purposes of this subpart; and

"(3) provides for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this subpart.".

Sec. 204. (a) Subpart III of part A of title VIII is repealed.

(b) Subpart IV of part A of title VIII is redesignated as subpart III.

(c) Section 820 (a) is amended to read as follows:

"SPECIAL PROJECT GRANTS AND CONTRACTS

"Sec. 820. (a) The Secretary may make grants to public and nonprofit private schools of nursing and other public or nonprofit private entities, and enter into contracts with any public or private entity, to meet the costs of special projects to—

"(1) increase the supply or improve the distribution by geographic areas or by specialty group of adequately trained nursing personnel (including nursing personnel who are bilingual) needed to meet the health needs of the Nation, including the need to increase the availability of personal health services and the need to promote preventive health care;

"(2) increase nursing education opportunities for individuals from underrepresented minority groups or disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, by—

"(A) identifying, recruiting, and selecting such individuals,

"(B) facilitating the entry of such individuals into schools of nursing,

"(C) providing counseling or other services designed to assist such individuals to complete successfully their nursing education,

"(D) providing, for a period prior to the entry of such individuals into the regular course of education at a school of nursing, preliminary education designed to assist them to complete successfully such regular course of education,

"(E) paying such stipends (including allowances for travel and dependents) as the Secretary may determine for such individuals for any period of nursing education, and

"(F) publicizing, especially to licensed vocational or practical nurses, existing sources of financial aid available to persons enrolled in schools of nursing or who are undertaking training necessary to qualify them to enroll in such schools;

"(3)(A) plan, develop, or establish new nurse training programs or programs of research in nursing eduction, or

"(B) significantly improve curricula of schools of nursing (including curriculums of pediatric nursing and geriatric nursing) or modify existing programs of nursing education;

"(4) provide continuing education for nurses;

"(5) provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession;

"(6) provide training and education to upgrade the skills of licensed vocational or practical nurses, nursing assistants, and other paraprofessional nursing personnel, or

"(7) assist in meeting the costs of developing short-term (not to exceed 6 months) in-service training programs for nurses aides and orderlies for nursing homes, which programs emphasize the special problems of geriatric patients and include training for monitoring the well-being and feeding and cleaning of the patients in nursing homes, emergency procedures, drug properties and interactions, and fire safety techniques.

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).".

(d) Section 820(d) is amended to read as follows:

"(d)(1) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1981, $16,000,000 for the fiscal year ending September 30, 1982, and $17,000,000 for the fiscal year ending September 30, 1983.

"(2) Not less than 20 percent of the funds appropriated under this subsection for any fiscal year shall be used for payments under grants and contracts to meet the costs of the special projects described in subsection (a)(1) and not less than 20 percent of such funds shall be used for such payments for special projects described in subsection (a)(2).".

(e) Subpart III of part A of title VIII (as redesignated by this section) is amended by adding the following new section after section 820:

"CLINICAL EDUCATION AND PRACTICE

"Sec. 821. (a) The Secretary may make grants to or enter into contracts with public or nonprofit private schools of nursing, or other appropriate public or nonprofit entities (determined by the Secretary to be capable of carrying out such grants or contracts) to—

"(1)(A) maintain, improve, increase, or extend the clinical education of students in schools of nursing, including providing for the establishment of new training opportunities relating to primary nursing care; or

"(B) assist in the establishment of arrangements between programs at schools of nursing and nursing practice settings in order to facilitate the clinical education of nursing students, or assist in demonstrating and evaluating new or improved arrangements;

"(2) plan, develop, operate or expand programs for the preparation of nurses in the various fields of advanced clinical practice, with special consideration given to the development or expansion of programs in geographic areas or regions in which there is a critical need for such nurses; and

"(3) demonstrate and evaluate new or improved patterns of nursing care that will promote the full utilization of nurses or assist in the retention or reentry of nurses in active nursing practice.

"(b)(1) There are authorized to be appropriated for grants and contracts under this section $15,000,000 for the fiscal year ending September 30, 1981, $18,000,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983.

"(2) Not less than 10 percent of the funds appropriated for grants and contracts under this section shall be provided for grants and contracts pursuant to subsection (a)(3).".

(f) Sections 821 and 822 are redesignated as section 822 and 823.

(g) Section 822 (as redesignated by this section) is amended to read as follows:

"ADVANCED NURSE TRAINING PROGRAMS

Sec. 822. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private collegiate schools of nursing to meet the costs of projects to plan, develop, and operate, significantly expand, or maintain existing programs for the advanced training of professional nurses in the various fields of nurse training to serve in administration, supervisory, teaching or research capacities, determined by the Secretary to require advanced training.

"(b) For payments for grants and contracts under this section there are authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1981, $11,000,000 for the fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983.".

(h) Section 823 (as redesignated by this section) is amended—

(1) by striking out "who are residents of a health manpower shortage area (designated under section 332)" after "to train nurse practitioners" in subsection (b)(1) thereof;

(2) by striking out "and" after "1979," in subsection (e) thereof; and

(3) by inserting the following before the period at the end of subsection (e): ", $18,000,000 for the fiscal year ending September 30, 1981, $20,000,000 for the fiscal year ending September 30, 1982, and $22,000,000 for the fiscal year ending September 30, 1983".

(i) Subpart III of part A of title VIII is amended by adding the following new section at the end thereof:

"DESIGNATION OF NURSE SHORTAGE AREAS

"Sec. 824. (a)(1) For purposes of this subpart the term 'nurse shortage area' means (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a shortage of nurses, including nurses in advanced clinical practice, (B) a public or nonprofit health services organization or agency that the Secretary determines has a shortage of nurses, including nurses in advanced clinical practice, or (C) a public or nonprofit private health care facility.

"(2) For purposes of this subsection, the term 'health care facility' means a facility for the delivery of health services, including—

"(A) a hospital, clinic, health center, hospice, or other facility providing acute medical, pediatric, or surgical services, obstetrical care, mental health care, long-term care, or rehabilitation services;

"(B) such a facility of a State correctional institution or of the Indian Health Service; and

"(C) a Federal medical facility, Federal facility, or other facility used in whole or in part to conduct Federal or federally assisted health programs.

"(3) For purposes of this subsection, the term 'health services organization or agency' means an organization or agency that has, as one of its principal functions, the delivery of nursing services, including public or community nursing services, home health services, and other nursing services for the public welfare, except that such term shall not include nurse registries, placement or recruitment agencies, or private duty nursing services.

"(b) The Secretary shall establish by regulation, promulgated not later than March 31, 1981, criteria for the designation of areas, health services organizations or agencies, or health care facilities, in the States, as nurse shortage areas. In establishing such criteria, the Secretary shall take into consideration the following:

"(1) The ratio of available nurses, including nurses in advanced clinical practice, to the number of individuals in an area or population group or served by facilities, organizations and agencies in an area, or in the region surrounding the facility, organization or agency in which it is reasonable to expect that nurses may be recruited for employment.

"(2) Indicators of a need for nurses, including nurses in advanced clinical practice, by facilities, organizations and agencies in an area, taking into consideration—

"(A) the ratio of nurses to bed-days and patient visits,

"(B) the type of patients served, and

"(C) the budgeted vacancies in such entities.

"(3) The number of nurses who are employed in nursing but not in direct nursing services.

"(c)(1) In accordance with the criteria established under subsection (b), the Secretary shall designate, not later than October 1, 1981, nurse shortage areas in the States, publish a descriptive list of the areas, organizations, agencies, or facilities, so designated, and at least annually review and, as necessary, revise such designations.

"(2) In making a determination under this subsection the Secretary shall take into consideration—

"(A) the recommendations of each health systems agency (designated under section 1515), for a health service area which includes all or any part of the area, or in which the organization, agency, or facility under consideration for designation is located; and

"(B) the recommendations of the Governor of each State in which the area, organization, agency, or facility under consideration for designation is located.

"(d) At least 30 days prior to the designation of a facility, organization, or agency as a nurse shortage area, the Secretary shall give written notice of such proposed designation to the chief administrative officer of such entity.

"(e) The Secretary shall give written notice of the designation of a nurse shortage area, not later than 60 days from the date of such designation, to—

"(1) the Governor of each State in which the area, organization, agency, or facility is located;

"(2)(A) each health systems agency (designated under section 1515) for a health service area which includes all or any part of the area, organization, agency, or facility so designated; or

"(B) the State health planning and development agency of the State (designated under section 1521) if there is a part of such area, organization, agency, or facility within a health service area for which no health systems agency has been designated; and

"(3) appropriate public or nonprofit private entities which are located or which have a demonstrated interest in the area so designated.

"(f) Any person may recommend to the Secretary the designation of an area, organization, agency, or facility as a shortage area.

"(g) Upon determining a nurse shortage area, the Secretary shall make such designation available to—

"(1) the public;

"(2) specific entities with an interest in such designation; and

"(3) entities in need of such information for the conduct of activities under this Act.".

Sec. 205. (a) Section 830(b) is amended—

(1) by striking out "and" after "1979,"; and

(2) by inserting the following before the period at the end thereof: ", $15,000,000 for the fiscal year ending September 30, 1981, $17,000,000 for the fiscal year ending September 30, 1982, and $19,000,000 for the fiscal year ending September 30, 1983".

(b) Section 831(b) is amended by inserting the following after "1980": ", $2,000,000 for the fiscal year ending September 30, 1981, $2,000,000 for the fiscal year ending September 30, 1982, and $3,000,000 for the fiscal year ending September 30, 1983".

Sec. 206. (a) Section 835(b)(4) is amended by striking out ", and that while the agreement remains in effect no such student who has attended such school before October 1, 1980, shall receive a loan from a loan fund established under section 204 of the National Defense Education Act of 1958".

(b) Section 836 is amended—

(1) by striking out "he" in subsection (b)(4) thereof and inserting in lieu thereof "the individual";

(2) by striking out "him" each place it appears and inserting in lieu thereof "the borrower"; and

(3) by striking out "his determination" in subsection (j) thereof and inserting in lieu thereof "determining".

(c) Section 837 is amended—

(1) by striking out "and for each of the next two succeeding fiscal years" after "1981,";

(2) by inserting "senior" after "may be necessary to enable"; and

(3) by striking out "continue or".

(d) Section 838 is amended—

(1) by striking out "he" and inserting in lieu thereof "the Secretary"; and

(2) by striking out "to him" in subsection (b)(2).

(e) Section 839 is amended to read as follows:

"DISTRIBUTION OF ASSETS FROM LOAN FUNDS

"SEC. 839. (a) After September 30, 1980, and not later than December 31, 1980, there shall be a capital distribution of the balance of the loan fund established under an agreement pursuant to section 835(b) by each school, except such distribution shall not include such amounts necessary to make loans to senior students under section 837, as follows:

"(1) The Secretary shall first be paid an amount which bears the same ratio to such balance in such fund at the close of September 30, 1980, as the total amount of the Federal capital contributions to such fund by the Secretary pursuant to section 835(b)(2)(A) bears to the total amount in such fund derived from such Federal capital contributions and from funds deposited therein pursuant to section 835(b)(2)(B).

"(2) The remainder of such balance shall be paid to the school.

"(b) After December 31, 1980, each school with which the Secretary has made an agreement under this subpart shall pay to the Secretary, not less often than quarterly, the same proportionate share of amounts received by the school after September 30, 1980, in payment of principal or interest on loans made from the loan fund established pursuant to such agreement as was determined for the Secretary under subsection (a).

"(c) The Secretary shall deposit amounts received pursuant to this section in the service contingent loan fund established under section 767F.".

(f) Section 841 is repealed.

SEC. 207. (a) Section 845(b) is amended to read as follows:

"(b) The amount of the grant under subsection (a) for the fiscal year ending September 30, 1981, and for each of the next two fiscal years to each such school shall be equal to $2,000 multiplied by one-tenth of the number of full-time students of such school. For the fiscal year ending September 30, 1984, and for each of the two succeeding fiscal years, the grant under subsection (a) shall be such amount as may be necessary to enable such school to continue making payments under scholarship awards to students who initially received such awards out of grants made to the school for fiscal years ending before October 1, 1983.".

(b) Section 845 is amended by adding the following new subsection at the end thereof:

"(f) If the total of the grants to be made under this section for any fiscal year to schools exceeds the amount appropriated for such grants, the amount of the grant for such fiscal year to each such school shall be ratably reduced.".

(c) Section 846 is repealed.

SEC. 208. (a) Section 851(a) is amended by striking out "shall be Chairman, and the Commissioner of Education" and inserting in lieu thereof "shall be Chairperson, and the Secretary of Education".

(b) Section 853(1) is amended by inserting "the Commonwealth of the Northern Mariana Islands," after "the Virgin Islands,".

(c) Section 853(8) is amended—

(1) by striking out "Commissioner of Education" each place it appears and inserting in lieu thereof "Secretary of Education"; and

(2) by striking out "(B)" after "this clause".

TITLE III—NATIONAL HEALTH SERVICE CORPS PROGRAM

SEC. 301. (a) Section 331 is amended by redesignating subsections (c), (d), (e), (f), (g), and (h) as subsections (e), (f), (g) (h), (i), and (j), respectively.

(b) Section 331 is amended by inserting after subsection (b) the following new subsections:

"(c) The Secretary shall conduct or support (through grant or contract) at schools of medicine, osteopathy, dentistry, and as appropriate, nursing and other schools of the health professions and at other appropriate entities, service preparatory programs for recipients of Corps scholarships. Such programs shall include—

"(1) didactic and clinical education in primary care in health manpower shortage areas as defined in section 332(a), including the establishment of preceptorships at existing Corps sites;

"(2) exposure to the unique problems of medically underserved populations; and

"(3) information dissemination and career counseling on practice and residency training opportunities in such manpower shortage areas.

"(d) The Secretary may enter into cooperative agreements with one or more schools or entities described in subsection (c) to accomplish the purposes set forth in subsections (b) and (c).".

(c) Section 331(f)(1)(B) (as redesignated by subsection (a)) is amended by striking out "his" and "he" each place it appears.

(d) Section 331(g) as redesignated by subsection (a)) is amended by striking out "Corps" and inserting in lieu thereof "Notwithstanding any other provision of law, Corps".

(e) Section 331(i) (as redesignated by subsection (a)) is amended to read as follows:

"(i) The administrative unit which administers parts E and F of title VII—

"(1) shall develop regulations, guidelines, funding priorities, and application forms, and

"(2) shall make recommendations to the Secretary in the review of applications and proposals for, and the awarding of, grants and contracts,

with respect to the Corps.".

(f) Section 331(j) (as redesignated by subsection (a)) is amended by—

(1) striking out "Health, Education, and Welfare" in paragraph (a) and inserting in lieu thereof "Health and Human Services", and

(2) inserting "the Commonwealth of" before "the Northern Mariana Islands".

SEC. 302. Section 332(a) is amended by adding at the end thereof the following new paragraph:

"(3) For the purposes of this subsection, a health manpower shortage of physicians shall be a shortage of primary care physicians in the specialties of family practice, general practice, internal medicine or pediatrics, or of physicians whose principal field of practice is obstetrics and gynecology, psychiatry, or such other specialty as determined by the Secretary.".

SEC. 303. (a) Section 333 (d) is amended by adding at the end thereof the following new sentence: "Prior to making any assignment in any health manpower shortage area other than to a medical facility as defined in section 333 (a) (2), the Secretary shall first seek to find service obligated scholarship recipients who wish to enter practice in such area pursuant to section 752.".

(b) Section 333 (e) is amended by adding before the period at the end thereof the following: ", provided that the Secretary shall first seek to assign to such area a Corps member who has such characteristics and who has completed the training, internship or residency in the State where such area is located.".

SEC. 304. (a) Section 334(a)(3)(B) is amended by striking out "the number of days in his period" and inserting in lieu thereof "the number of days in the period".

(b) Section 334(b)(1) is amended by striking out "he" each place it appears and inserting in lieu thereof "the Secretary".

(c) Section 335 is amended by striking out "he" each place it appears and inserting in lieu thereof "the Secretary".

(d) Section 336(3) is amended by inserting "and individuals released under section 752 from their service obligation" after "the number and types of Corps members".

(e) Section 338(a) is amended by—

(1) striking out "and" after "September 30, 1979,"; and

(2) inserting before the period at the end thereof "; $125,000,000 for the fiscal year ending September 30, 1981; $300,000,000 for the fiscal year ending September 30, 1982; and $360,000,000 for the fiscal year ending September 30, 1983".

SECTION-BY-SECTION SUMMARY

Section 1. Act cited as "Health Professions Training and Distribution Act of 1980."

Section 2. Findings and declarations of the Congress: Congress finds that the goal of the health care system to provide all Americans with equal access to high-quality health care at a reasonable cost is dependent, in part, on the availability of qualified health professionals; that the accomplishment of the goal is jeopardized by the high price of education, high levels of student indebtedness, underrepresentation of minorities and women, continuing need for health professionals trained in primary care, wide disparity in the availability of health professionals, and a critical inability of many communities to obtain and retain nurses. Congress declares that the federal government's partnership with the nation's health professions schools and students is reaffirmed in order to assure equal opportunity for Americans to enter a health career and to assure equal access of all Americans to qualified health personnel.

Section 3. Amendments are to the Public Health Service Act.

Section 4. Effective date October 1, 1980.

Title I—Health Personnel Training and Distribution:

Section 101. Amends the title of Title VII to "Health Personnel Training and Distribution" and amends Section 700 to set forth the general duties of the Secretary for training sufficient numbers of health personnel to meet the health care needs of the United States.

Section 102. Changes the name of the National Advisory Council on Health Professions Education to the National Advisory Council on Health Personnel, expands the Council and includes membership of a representative from an allied health training center and interns or residents. Revises the health personnel data collection, compilation, and analysis authority and sets forth periodic reports by the Secretary to the Congress concerning health personnel and health students in the United States. Provision is made to protect the confidentiality of individually identifiable personal data. A general technical assistance authority is added.

Section 103. Amends and extends the authority to make grants and loan guarantees and interest subsidies for construction of teaching facilities for medical, dental, and other health personnel. Removes the restriction that construction of ambulatory primary care teaching facilities be limited only to those facilities for training physicians or dentists. Makes separate authorizations for appropriations for construction of general teaching facilities and for the construction of ambulatory primary care teaching facilities.

Eliminates projects to prevent the curtailment of enrollment as an eligible purpose under the construction program. Adds a new priority for construction projects for schools that are expanding from a two-year to a four-year program and for new schools that anticipate predominantly minority student enrollment.

Provides to the Secretary authority, after consultation with the National Advisory Council on Health Personnel, to reduce or eliminate enrollment-increase requirements previously imposed on grantees under the construction program. Prohibits the promulgation of regulations which would provide for enrollment increases for the purpose of establishing eligibility for construction loan guarantees or interest subsidies.

Continues the loan guarantee and interest subsidy program for construction projects but authorizes increased interest subsidization for projects initially guaranteed or subsidized after October 1, 1980. Authorizes the Secretary to enter into new loan guarantee and interest subsidy agreements for construction projects for a cumulative total of principal equal to the amount authorized for grants under the construction program.

Section 104. Extends the federal program of insured loans to students in health professions schools. The limitations on individual, federally insured loans and on federal loan insurance is increased and students in graduate programs in health administration, collegiate schools of nursing, or physician assistant or expanded function dental auxiliary training programs become eligible to participate. Removes the restriction that students cannot borrow, in the same year, under this program and the guaranteed student loan program of the Higher Education Act. Adds reasonable living expenses to costs for which insured loans may be made.

Extends the period of deferment of principal and interest payments and permits deferment but accrual of interest during such periods. Adds a graduated repayment option and a variable interest option. Reestablishes a maximum interest on the unpaid principal balance of the loan to the average of the bond equivalent rates on 91-day treasury bills plus 3 percent. Eliminates the requirement that interest payments on loans insured under the program must be made during deferment periods. Adds a new provision for the Secretary to discharge the borrower's liability under the program in the event a borrower fails to complete the first year of studies leading to the first professional degree, under certain circumstances. Eliminates the authority of the Secretary to enter into a written contract with a borrower under the program to discharge a portion of the loan obligation for service in a health manpower shortage area. (Borrowers would be eligible to participate in a new general loan repayment authority).

Section 105. The health professions student loan program is continued through fiscal year 1981 but only for senior students who had previously received a loan under the program in order for them to complete their education. Capital distribution of the school loan funds will begin in fiscal year 1981 and be deposited by the Secretary into the fund for the new service contingency loan program.

Section 106. A new service contingent loan program is authorized. The program provides need-based, campus-originated loans to students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, schools of nursing, graduate programs in health administration, and programs for the training of physician assistant or expanded function dental auxiliaries. Interest on student loans is completely subsidized during the period a student is in school and for a variable period of graduate training, depending on the profession, thereafter. During the repayment period, loans would bear 7 percent interest except for loans made to students in schools of nursing or public health, or in programs in health administration, physician assistant training or expanded function dental auxiliary training, which would bear 5 percent interest. Additional periods of deferral of principal and interest payments, but interest accrual, are provided for periods of graduate training, service in the armed forces, VISTA, Peace Corps, underserved areas, and the National Health Service Corps.

In return for interest subsidization, the borrower may at the discretion of the Secretary, be requested to provide national service in positions designated by the Secretary to be national priority needs. This borrower liability would exist only at the beginning of the loan repayment period. Students would first be asked to volunteer for positions designated by the Secretary. Remaining positions would be filled by the Secretary by lot from remaining borrowers. The Secretary will discharge the entire loan obligation of the student borrower under the program in return for the requested service.

To finance the program, the Secretary is authorized to borrow fom the Treasury, off budget, with established annual borrowing limits.

Appropriation authorizations are provided to meet interest insufficiencies in the program and to permit the Secretary to discharge the loan obligations of the borrowers who are requested to provide service by the Secretary.

Section 107. Continues the program of traineeships to students in schools of public health and graduate programs of health administration but removes the requirement that 66% of the traineeships go to students who have received post baccalaureate degrees or have had three years of work experience in health services. Instead, traineeships are to be distributed among the schools and programs proportionate to the needs of the students.

Section 108. The National Health Service Corps scholarship program is continued. The priorities in awarding scholarships are amended to include, as a second priority, students who have borrowed under the service contingency loan program.

In making new awards to students in schools of medicine and osteopathy, 90 percent of the awards are to be set aside by the Secretary for the purpose of providing scholarships to eligible applicants in schools of medicine and osteopathy in each State proportionate to the need for physicians to provide services in shortage areas in the State.

The Secretary is required to approve scholarship applications prior to August 1 of each year and to promptly notify the educational institutions of the award.

A single administrative unit is to administer the scholarship program, the National Health Service Corps programs and the educational support programs in Parts E and F of Title VII.

The option for National Health Service Corps scholarship recipients to fulfill their obligations through an independent practice arrangement is continued, but the option is expanded to include individuals who receive scholarships under the Public Health Service Scholarship program, the forerunner to the National Health Service Corps Scholarship program. The requirement that a sufficient financial base to sustain practice and to provide the individual with income equivalent to the income of members of the Corps is removed and a new requirement that individuals serving under the independent practice option agree to accept assignment under the independent practice option agree to accept assignment under the medicare program is added. The Secretary is authorized to provide such individuals technical assistance and the individual is required to provide periodic reports on the individual's practice to the Secretary. In order to assist individuals establish their practice in shortage areas, income subsidization and the cost of malpractice insurance is authorized. In addition, eligibility of special grants, previously limited to former Corps members, is extended to individuals entering this practice agreement.

The distribution of scholarships among different types of professional students is amended to require 90 percent in medicine and osteopathy.

Section 109. Retains the exceptional financial need scholarship program for first-year students but changes the distribution of funds among eligible health professions schools and reestablishes the maximum amount of the award to any student.

Adds a new program for the Secretary to repay up to 80 percent of a student's educational loans if the student serves for up to four years in a health manpower shortage area.

Section 110. Repeals the health professions capitation grant program. Establishes a new national priority incentive grant program. Annual grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and public health are authorized for the support of their educational programs and projects and activities that are in the national interest.

For schools of medicine, the amount will be increased if objectives are met related to—the enrollment of underrepresented minority groups; the enrollment of women; the graduation of students entering family practice; the distribution of residency training physicians in primary care; the enrollment of students from health manpower shortage areas and the conduct of clinical education in primary care setting; the offering of education in nutrition, geriatrics, prevention, health care economics or rehabilitation, or the preparation of students to pursue careers in clinical investigation. The amount will be decreased if the school increases tuition or enrollments excessively.

For schools of osteopathy, the amount will be increased if objectives are met related to—the enrollment of students from underrepresented minority groups; enrollment of women; the conduct of programs for the training of faculty in primary care; the conduct of clinical training in medically underserved areas or the conduct of curricular offerings in nutrition, geriatrics, prevention, health care economics, or rehabilitation. The amount will be decreased if the school increases its tuition or enrollment excessively.

For schools of dentistry, the amount will be increased if the national objectives are met related to—the enrollment of students from underrepresented minority groups; the enrollment of women; the entry of graduates into general practice dentistry; the establishment of new residency training programs in public health, general practice or pedodontics; the enrollment of students from health manpower shortage areas and the conduct of education in areas where underserved populations reside; and the conduct of curricular offerings in dental care to the elderly, preventive or community dentistry, nutrition, or health care economics. The amount will be decreased for excessive tuition or enrollment increases.

For each school of veterinary medicine, the amount will be increased for objectives that are met related to—the enrollment of students from underrepresented minority groups; the enrollment of women; enrollment of students from States which do not have schools of veterinary medicine, and clinical training emphasizing the care of food and fiber producing animals.

For schools of optometry, the amount will be increased if national objectives are met related to—the enrollment of students from underrepresented minority groups; the enrollment of women; and the maintenance of first-year enrollment or the enrollment of students from States which do not have accredited schools; and the offering of courses in developmental, rehabilitative or geriatric optometry, or in underserved areas.

For each school of podiatry, the amount would be increased if national objectives are met related to—the enrollment of students from underrepresented minority groups or who are women, the maintenance of first-year enrollment or the enrollment of students from States which do not have schools of podiatry; or the conduct of curricular offerings in meeting the footcare needs of the elderly.

For schools of pharmacy, the amount of the grant will be increased if national objectives are met related to—the enrollment of students from underrepresented minority groups or who are women, training in clinical pharmacy and drug information, or the offering of courses related to geriatrics, nutrition, prevention, mental health care, or health care economics.

For schools of public health, the amount will be increased if national objectives are met related to—the enrollment of students from underrepresented minority groups, the enrollment of students pursuing courses in epidemiology and biostatistics, health administration, nutrition, international health, occupational health or environmental health, and the proportion of students receiving graduate degrees who enter public service. The amount will be decreased if the school increases its tuition excessively or does not maintain its enrollment.

For grant computation purposes, each student at schools with predominant underrepresented minority student enrollment will be counted three times, and such new schools will be eligible to participate in the program in the year before instruction is initiated.

Section 111. Amends Part F related to grants and contracts for programs and projects in the health professions by:

Consolidating and extending the authority to support programs for training in family medicine.

Extends the area health education center program and requires the Secretary to give priority to programs which will serve an entire state.

Extends the program for the training of physician assistants and adds a traineeship authority.

Extends the program for training in primary care internal medicine and pediatrics and adds authority for faculty development.

Combines and extends the authorities for the training of expanded function dental auxiliaries, for training dental students in the organization and management of dental teams, and for the support of general practice dentistry residencies.

Extends and expands the existing program to assist individuals from underrepresented minority groups and disadvantaged backgrounds to undertake education to enter a health profession.

Extends start-up assistance to new schools only for those schools which receive support prior to October 1, 1980.

Extends financial distress grant authority and adds eligibility for schools of nursing but restricts such grants to no more than three consecutive years. Adds a new authority for the Secretary to enter into cooperative agreements (for up to five years) with health professions schools that are especially meeting the needs of underserved populations in order to remove the schools from serious or long-standing financial instability.

Provides a new authority for the Secretary to support projects related to the enrollment of students who are committed to serve medically underserved populations or to provide training in medically underserved areas.

Adds a new authority to assist two-year schools of medicine to convert to degree granting institutions.

Adds a new authority to support training, including residency training, in preventive or community medicine or dentistry, including occupational medicine.

Adds new authorities to support special curricular offerings related to training in optometry, podiatry, pharmacy and veterinary medicine; to support training in nutrition, geriatrics, rehabilitation, and the containment of health care costs; to increase participation of women in health careers and to encourage the advancement of women in such careers, and to conduct research and demonstration projects.

Section 112. Extends the programs for training in public health, health administration and in allied health but adds new requirements for cost-sharing and education related to cost-containment for programs in health administration.

Repeals traineeship authority for advanced training in allied health professions education in lieu of a new project purpose for advanced training and repeals traineeships for the disadvantaged in lieu of the addition of allied health training center eligibility under the general disadvantaged assistance authority.

Title II—Nurse Education Amendments:

Section 201. Cites the title as the "Nurse Education Amendments of 1980."

Section 202. Extends the program of nursing grant, loan guarantees and interest subsidies for construction of nursing education facilities for three years and liberalizes interest subsidy payments for new projects. Limits the amount of loans guaranteed or for which interest subsidies are paid to the amount of funds obligated annually for grants.

Section 203. Repeals the capitation grant program. Establishes a new program of national priority incentive grants to support the education programs of schools of nursing and other projects and activities that are in the national interest.

The incentive grant program increases the amount of support to any school of nursing which increases the number of students in a senior or graduating class, which has a substantial portion of its graduates entering service in areas with few nurses, which provides opportunities for registered nurses to complete a degree in nursing, or which provides substantial educational opportunities for students from underrepresented minority groups or disadvantaged backgrounds. The amount would be decreased if a school did not maintain its first year enrollment.

Section 204. Repeals the financial distress program.

(Nursing schools are made eligible for financial distress under Title VII.)

Reauthorizes the nursing special project grant authority with minor modification—the elimination of authority to award funds for mergers, and the addition of the requirement that 20 percent of the funds appropriated be used for projects related to the distribution of nurses, and 20 percent for projects to increase the enrollment of students from disadvantaged backgrounds.

Adds a new authority to support the clinical education and practice of nurses, including the education of nurses for advanced clinical practice, and to demonstrate and evaluate new patterns of nursing care that will increase retention of nurses and promote full utilization of their skills.

Extends the advanced nurse training program for the training of professional nurses for administrative, supervisory, research or teaching roles.

Continues the nurse practitioner authority but eliminates the requirement that traineeships be awarded to residents from health manpower shortage areas.

Adds a new section requiring the designation of nurse shortage areas.

Section 205. Continues traineeships for nurses in advanced training and for nurse anesthetists.

Section 206. Limits the nursing student loan program in fiscal year 1981 to awards to senior students to complete their education and distributes the capital in the loan funds to the service contingent loan fund under Title VII. (Nursing students are eligible for the new service contingent loan program.)

Repeals the authority to transfer money between the nursing student loan program and the nursing scholarship program.

Section 207. Continues the nursing scholarship program with a provision that grants will be ratably reduced dependent on the amount of appropriations.

Section 208. The National Advisory Council on Nurse Training is retained, as are the other general provisions of Title VIII.

Title III—National Health Service Corps Program:

Section 301. Adds a requirement that the Secretary conduct or support appropriate training for National Health Service Corps Scholarship recipients to prepare them for service to medically underserved populations.

Section 302. Requires that designations for health manpower shortage areas for physicians be specialty specific.

Section 303. Requires that the Secretary first seek an obligated scholarship recipient under the independent practice option before assigning a member of the Corps to a health manpower shortage area but limits such requirement to assignments to other than a medical facility such as a community health center. Also requires the Secretary to seek a first scholarship recipient who has completed his or her training in the State where the area is located.

Section 304. Extends the National Health Service Corps program for three years.

PROPOSED AUTHORIZATIONS

[In millions; fiscal years]

	1980 authorization in current law	Proposed		
		1981	1982	1983
Title VII of Public Health Service Act	$814.27	[illegible]	$533.5	$603.7
Title VIII of Public Health Service Act	103.0	106.0	110.0	129.0
National Health Service Corps program	82.0	123.0	208.0	250.0
Total	999.27	766.4	851.5	982.7

[From the Congressional Record—Senate, December 17, 1979]

Introductory Statement of Mr. Schweiker on S. 2144

By Mr. SCHWEIKER:

S. 2144. A bill to amend the Public Health Service Act to revise titles VII and VIII of such Act to provide new programs for training in the health professions and nursing, and for other purposes; to the Committee on Labor and Human Resources.

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

Mr. SCHWEIKER. Mr. President, I am today introducing the "Health Professions Educational Assistance and Nurse Training Act of 1980." This bill is a comprehensive reexaminaton of titles VII and VIII of the Public Health Service Act which provide for Federal programs affecting the education of health professionals and nurses. I am particularly proud of this bill because I believe it meets three important tests by which legislation should be judged. First, the bill would accomplish national goals in a direct and positive manner. Second, the bill represents a fiscally sound approach, blending needed budgetary restraint with adequate funding for programs that meet serious educational and health care problems. Third, the bill carefully avoids the imposition of further regulatory schemes upon our citizens and resists the temptation to create long-term programmatic structures and give aways that quickly become next year's uncontrollable expenditures. Instead the bill emphasizes that there are no free rides and stresses at every opportunity the value of inducements.

I believe we should continue student aid, because otherwise, the health professions would be only for the very rich.

Federal student assistance should also be based upon the fact that there is a need for more health professionals generally. Although a surplus of physicians is forecast during the 1980's, there will still be shortages by specialty and in the geographic distribution as well as a need for non-M.D. professionals.

But those who finish their education will be in a position to earn substantial incomes. They should be expected to help pay for their education.

So this legislation, while recognizing the high cost of training, signals and end to the free ride.

I am convinced that with encouragement from us, many health professionals will do voluntarily what we could not ask them to do otherwise. This bill provides considerable encouragement for individuals to practice their profession in underserved areas and to provide primary care, and for health professions schools to teach more about health promotion and disease prevention, about health care policy and economics, and about nutrition.

I will briefly describe the programs contained in this bill and discuss how each of the three principles—achievement of national goals, fiscal restraint, and use of inducements rather than regulation—are represented.

For the health professions schools (medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy) and their students, my bill would provide:

A new student loan program, utilizing the existing private loan markets, which would provide modest interest subsidies while the student is in school, but would be a market rate loan once the student is in practice;

Increased availability of loan forgiveness inducements for health professionals who practice in medically underserved area;

Expanded special projects grants to assist schools in carrying out programs designed to improve the geographic and specialty distribution of health professionals and to establish and strengthen curriculum offerings in key areas;

Special supplementary awards as part of each special projects grant made to a health professions school which is carrying out activities deemed to be in the national interest;

A new program of grants to States for service scholarship programs, thus involving States in solving geographic distribution problems;

Startup assistance only for schools of veterinary medicine, optometry, podiatry, and public health;

A new financial distress grant program, keyed to State and local support, for schools with long-term financial problems; and

A revised construction program which, instead of paying for new buildings, provides grants and interest subsidies for the renovation, modernization and conversion of existing facilities for use in teaching and research;

For schools of nursing and their students, my bill would provide:

Expanded special projects grants to assist schools in carrying out programs for advanced nurse training, nurse practitioner training, curriculum development, support for practicing nurses, and improvement of nursing education;

Special supplementary awards as part of each special projects grant that is made to a school of nursing which is carrying out activities deemed to be in the national interest;

Continuation of the nursing student loan program for 4 more years as a transition period during which nursing schools can begin to more fully utilize the guaranteed student loan program and other student assistance programs under the Higher Education Act.

A new start-up assistance program and a new financial distress program; and

A revised construction program for renovation, modernization, and conversion of existing facilities for use in nurse training.

My bill also proposes three other major policy shifts. Capitation grants, direct subsidies which have been provided to health professions and nursing schools, are discontinued. These grants, which have served useful purposes in the past, do not adequately assure that institutions receiving the grants are acting in the national interest and thus deserving of the money. We are in a time in which all Americans must restrain the demands they place upon the Federal budget. In these circumstances, capitation is a luxury we cannot afford.

Another policy change is to phase down, over a 3-year period, the National Health Service Corps scholarship program to about one-third of its fiscal year 1980 level. This program has, rather unfortunately I think, been expanded because of the demand for scholarship money for health professions students, rather than by a responsible assessment of the actual need for health professionals in nonmilitary service in 1985 and beyond; the general desirability or undesirability of a civilian Federal health corps; and the extraordinary cost to the Federal Government when these scholarship recipients join the Federal payroll and deliver health services under their scholarship commitments. In 1980 the field strength of the National Health Service Corps will be 2,830 individuals, at an estimated cost of $82 million. By 1985 this is expected to increase to 6,834 individuals assigned to provide service, at a cost of $275 million. Frankly, I do not think we will need anywhere near that many in 1985. Nor do I believe the Federal Government should be so massively involved in the direct delivery of health care services. Health care provided by the Federal Government is inefficient, insensitive to local needs, and makes it more difficult for nonscholarship physicians and dentists to set up a private practice in the same geographic area. As an alternative, I am proposing a Federal program of grants to States to fund State service scholarships. States should be encouraged to be more involved in meeting the needs of their medically underserved areas. They will also be much more inclined than HEW to let the scholarship recipients serve in private practice, which is a less costly, more stable, and more enduring means of meeting health care needs than the National Health Service Corps.

Finally, another major shift is away from giveaways and toward programs which focus directly on meeting our national health care needs. A key example is in the student assistance area where my bill stresses that every student should be responsible for the cost of his or her education, to be paid from their increased earning potential. Instead of scholarships and low-cost loans for a very few, I have proposed a very modestly subsidized loan program for students while they are in a health professions school; the student would be responsible for only 7 percent interest, repayment of which can be deferred. This subsidy will help moderate the more extreme debt situations. After the student is out of school, he or she would be responsible for the loan, at unsubsidized market interest rates. Individuals who act in the national interest, for example by receiving training in primary care, practicing in a medical shortage area, or entering a research career, would be entitled to continue to receive the interest subsidies. In addition, partial loan forgiveness will be more readily available for health professionals entering practice in an underserved area. I believe this is a more direct, more positive, and more equitable way of meeting the needs of our health professions students while keeping Federal costs minimal and encouraging individuals to act in the national interest.

In concluding, I feel it worth repeating that my bill is designed to maximize Federal impact on the health professions and nursing, students and schools, without extravagant spending or regulation. This bill authorizes for fiscal year 1981 for these programs, a mere 8 percent more than was appropriated in fiscal year 1980. Yet I am convinced that the legitimate needs of students and schools, as well as the Federal Government, are fairly and adequately met by this legislation.

At this time, I ask unanimous consent to have printed in the RECORD an analysis of the bill, a section-by-section summary, two authorization charts, and the text of the bill.

There being no objection, the bill and material were ordered to be printed in the RECORD, as follows:

S. 3164

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Professions Educational Assistance and Nurse Training Act of 1980".

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

FINDINGS AND DECLARATION OF POLICY

SEC. 2. (a) The Congress finds that—

(1) the availability of high quality health care to all Americans is a national goal that can be met in the 1980's if the United States continues to train well qualified health professionals and nurses in sufficient numbers, and encourages such health professionals and nurses to practice among populations and in locations presently lacking adequate health services, and in types of practice for which there is an urgent need for additional practitioners;

(2) previous health manpower Acts have succeeded in alleviating the long-term shortage of allopathic physicians, osteopathic physicians, and dentists and have greatly improved the availability of health personnel in other health fields;

(3) the Federal Government can significantly contribute to improving geographic and specialty distribution of physicians in the 1980's without imposing a burdensome regulatory scheme to accomplish such goals; and

(4) in the 1980's there is likely to be an increase in public demand that health professionals, nurses, and allied health personnel receive high quality, broadly based, educational opportunities.

(b) The Congress declares that it is therefore appropriate to support the education and training of health professionals, nurses, and allied health personnel in order to encourage better specialty and geographic distribution and to ensure the initial and continuing competency of such professionals, nurses, and personnel.

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TITLE I—HEALTH PROFESSIONS AND ALLIED HEALTH PERSONNEL

SHORT TITLE

Sec 101 This title may be cited as the "Health Professions Educational Assistance Act of 1980".

AMENDMENTS TO TITLE VII

Sec 102 Title VII is amended—

(1) by striking out Parts A, B, D, E and G;

(2) by striking out section 739 and redesignating section 780 as section 739;

(3) by redesignating Subpart IV of Part C as Subpart II of Part D;

(4) by redesignating sections 751, 752, 753, 754, 755, 756, and 757, as sections 765, 766, 767, 768, 769, 770, and 771, respectively;

(5) by redesignating sections 732, 733, 734, 735, 736 and 737 as sections 722, 723, 724, 725 and 726 respectively;

(6) by striking out sections 727, 728, 729, 730, 731, 734, and 738; and

(7) by striking out Subparts II, III, and V of Part C

TITLE

Sec 103 The title of title VII is amended to read as follows:

"TITLE VII—TRAINING OF HEALTH PROFESSIONS AND ALLIED HEALTH PERSONNEL"

GENERAL PROVISIONS, STUDENT LOANS

Sec 104 Title VII is amended by inserting the following after the title:

"Part A—General Provisions; Financial Distress and Start-Up Grants

"DEFINITIONS

"Sec 700 (a) For purposes of this title

"(1) The term 'nonprofit' refers to the status of an entity owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual

"(2) The terms 'school of medicine', 'school of osteopathy', 'school of dentistry', 'school of veterinary medicine', 'school of optometry', 'school of podiatry', 'school of pharmacy', 'school of public health', and 'graduate program in health administration' mean an accredited public or nonprofit private school or program in a State that provides training leading respectively to a degree of doctor of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry, a degree of bachelor of science in pharmacy, a graduate degree in public health, and a graduate degree in health administration, respectively, and includes equivalent degrees and advanced training related to such degrees provided by any such school.

"(3) The term 'teaching facilities' means facilities used by students, faculty, or administrative personnel for clinical purposes, research activities, libraries, classrooms, offices, auditoriums, dining areas, student activities, or other related purposes necessary for and appropriate to, the conduct of comprehensive programs of education. Such term includes interim facilities designed to provide teaching space on a short-term (less than ten years) basis while facilities of a more permanent nature are being planned and constructed but does not include off-site improvements or living quarters.

"(4) The term 'ambulatory, primary care teaching facilities' means facilities for the training of students in the diagnosis and treatment of ambulatory patients primarily in the specialties of family medicine, general pediatrics, general internal medicine, general dentistry, and pedodontics. Such facilities include examination rooms, clinical laboratories, libraries, classrooms, offices, and other areas for clinical or research purposes necessary for, and appropriate to, the conduct of comprehensive ambulatory, primary care training of allopathic physicians, osteopathic physicians, and dentists in such specialities.

"(5) (A) The term 'program for the training of physician assistants' means an educational program that has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to effectively provide health care as a physician assistant under the supervision of a physician.

"(6) (A) The term 'program for the training of expanded function dental auxiliaries' means an educational program that has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to assist in the provision of dental care as an expanded function dental auxiliary under the supervision of a dentist.

"(7) The term 'allied health personnel' means individuals with training and responsibilities for the facilitation or delivery of health care services (including the assistance of health professionals, and diagnostic, dietary, rehabilitative and preventive health services) who are not graduates of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, or graduate programs in health administration.

"(8) The terms 'training center for allied health personnel' and 'school of allied health' mean a public or nonprofit private junior college, college, or university—

"(A) which provides, or can provide, programs of education in a field of allied health leading to a baccalaureate or associate degree (or an equivalent degree of either) or to a more advanced degree;

"(B) which provides training for not less than a total of twenty persons in such curricula;

"(C) which, if in a college or university which does not include a teaching hospital or in a junior college, is affiliated with such a hospital; and

"(D) which is (or is in a college or university which is) accredited by a recognized body or bodies approved for such purposes by the Secretary of Education, or which is in a junior college which is accredited by the regional accrediting agency for the region in which it is located or there is satisfactory assurance afforded by such accrediting agency to the Secretary that reasonable progress is being made by such junior college toward accreditation.

"(9) The term 'Secretary' means the Secretary of the Department of Health and Human Services.

"(10) The term 'Department' means the Department of Health and Human Services.

"(11) The term 'Council' means the National Advisory Council on Health Professions Education, as provided in section 701 of this Act.

"(12) The term 'State' includes, in addition to the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

"(13) The term 'accredited' when applied to a school of medicine, osteopthy, dentistry, veterinary medicine, optometry, podiatry, pharmacy or public health, means a school that is accredited by a recognized body or bodies approved for such purpose by the Secretary of Education, except that a new school that, by reason of an insufficient period of operation, is not, at the time of application for a grant or contract under this title, eligible for accreditation by such a recognized body or bodies, shall be deemed accredited for purposes of this title, if the Secretary of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of the first entering class in such school.

"(b) Whenever in this title an applicant is required to provide assurances to the Secretary, or an application is required to contain assurances or be supported by assurances, the Secretary shall determine before approving the application that the assurances provided are made in good faith.

"NATIONAL ADVISORY COUNCIL ON HEALTH PROFESSIONS AND ALLIED HEALTH EDUCATION

"Sec. 701. (a) There is established in the Public Health Service a National Advisory Council on Health Professions and Allied Health Education (hereinafter in this title referred to as the 'Council'), consisting of the Secretary (or his delegate) who shall be Chairman of the Council, and twenty-one members appointed by the Secretary (without regard to the provisions of title 5 of the United States Code relating to appointments in the competitive service) from among persons who because of their education, experience, or training are particularly qualified to advise the Secretary with respect to the programs of assistance authorized by this title. The members of the Council shall be appointed as follows:

"(1) twelve shall be representatives of health professions schools and allied health training centers, including at least one representative, each of schools of veterinary medicine, optometry, pharmacy, and podiatry, at least one representative of allied health training centers, and at least one representative of schools of public health and graduate programs in health administration;

"(2) three shall be full-time students enrolled in health professions schools or allied health training centers, and

"(3) six shall be members of the general public.

"(b) The Council shall advise the Secretary in the preparation of general regulations and with respect to policy matters arising in the administration of this title.

"(c) The Secretary may use the services of any member or members of the Council in connection with matters related to the administration of this title, for such periods, in addition to conference periods, as he may determine.

"(d) Notwithstanding section 14 of the Federal Advisory Committee Act, the Council shall remain in existence until otherwise provided by law.

"ADVANCE FUNDING

"Sec. 702. An appropriation under an authorization of appropriations for grants or contracts under this title for any fiscal year may be made at any time before such fiscal year and may be included in an Act making an appropriation under such authorization for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation for such grants or contracts before the fiscal year for which such appropriation is authorized.

"DISCRIMINATION ON THE BASIS OF SEX AND RACE PROHIBITED

"Sec. 703. The Secretary may not enter into a contract with or make a grant, loan guarantee, or interest subsidy payment under this title to, or for the benefit of, any school, program, or training center which is eligible to receive assistance under programs authorized by this title unless the contract or the application for the grant, loan guarantee, or interest subsidy payment contains assurances that the school, program or training center will not discriminate on the basis of sex or race in the admission of individuals to its programs.

"RECORDS AND AUDITS

"Sec. 704. (a) Each entity that receives a grant, loan, loan guarantee, or interest subsidy or that enters into a contract under this title, shall establish and maintain such records as the Secretary shall by regulation or order require.

"(b) Each entity that received a grant or entered into a contract under this title shall provide for a biennial financial audit of any books, accounts, financial records, files, and other papers and property that relate to the disposition or use of the funds received under such grant or contract. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with the standards and requirements of the individual or agency that conducts the audit and any standards applicable to the performance of the audit, as the Secretary may by regulation provide.

"(c) A student recipient of a service scholarship, traineeship, loan, loan guarantee, or interest subsidy under this title shall not be required to comply with subsection (a) or (b).

"(d) Each entity that is required to establish and maintain records or to provide for an audit under this section shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable request therefor.

"CONTRACTS

"Sec. 705. Contracts authorized by this title may be entered into without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529, 41 U.S.C. 5).

"APPLICATIONS AND PAYMENT

"Sec. 706. (a) No grant may be made or contract entered into under this title unless an application therefor has been submitted to and approved by the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(b) Grants made under this title may be paid—

"(1) in advance or by way of reimbursement,

"(2) at such intervals and on such conditions as the Secretary may find necessary, and

"(3) with appropriate adjustments on account of overpayments or underpayments previously made.

"DIFFERENTIAL TUITION AND FEES

"Sec. 707. The Secretary may not enter into a contract with, or make a grant, loan guarantee, or interest subsidy payment under this title or title VIII to or for the benefit of, any school, program, or training center if the tuition levels or educational fees at such school, program, or training center are higher for certain students solely on the basis that such students are the recipients of traineeships, loans, loan guarantees, service scholarships or interest subsidies from the Federal Government.

"HEALTH PERSONNEL DATA

"Sec. 708. (a) The Secretary shall establish within the National Center for Health Statistics and the Bureau of Health Manpower jointly, a program to collect, compile and analyze data on health personnel, including a uniform health professions data reporting system. Such program shall include data respecting allopathic and osteopathic physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, nurses (in conjunction with section 808 of this Act), public health personnel, audiologists, speech pathologists, medical technologists, other allied health personnel, and any other health personnel in States designated by the Secretary to be included in the program. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional), place or places of practice, professional specialty, practice characteristics, age, sex, and socio-economic background of health personnel and other demographic information regarding health personnel.

"(b) In carrying out subsection (a), the Secretary shall collect available information from appropriate local, State, and Federal agencies and other appropriate sources, and may enter into contracts, when necessary, to obtain such information, subject to the provisions of section 709.

"(c) The Secretary shall conduct, or enter into contracts for the conduct of, analytic and descriptive studies of health personnel, including evaluations and projections of the supply of, and requirements for, health personnel by specialty, geographic location, type of activity, and degree of utilization of auxiliary personnel.

"(d) Any school, program, or training center receiving funds under this title shall submit a report to the Secretary on an annual basis, containing such information as is necessary to assist the Secretary in carrying out this section. The Secretary shall not require the collecting or transmittal of any information under this subsection which is not readily available to such school, program, or training center. Information under this subsection shall be collected or transmitted only to the extent permitted by section 709.

"(e) The Secretary shall submit, on a biennial basis, a report to the President and Congress on the status of health personnel in the United States. Such report shall include a description and analysis of the information collected pursuant to this section.

"(f) There are authorized to be appropriated to carry out the purposes of this section $4,000,000 in the fiscal year ending September 30, 1981 and $3,000,000 in each of the subsequent three fiscal years.

"PERSONAL DATA

"Sec. 709. (a) The Secretary and any entity receiving funds under title VII, in securing and maintaining any record of individually identifiable personal data (hereinafter in this subsection referred to as 'personal data') for the purpose of carrying out section 708 or any grant or contract under this title, shall—

"(1) inform each individual who is asked to supply personal data whether such individual is legally required to supply such data and the specific consequences of providing or not providing such data; and

"(2) upon request of an individual, inform such individual—

"(A) as to whether such individual is the subject of personal data secured or maintained by the Secretary or entity pursuant to this title, and make such data available to such individual in a form comprehensible to him, and

"(B) concerning the use of personal data respecting such individual, the identity of the persons who will use such data, and the relationship of such persons to the grant or contract required such personal data under this title.

"(b) (1) Personal data collected by the Secretary, entity, or local, State, or Federal agency pursuant to this title may not be made available or disclosed by the Secretary, entity, or local, State, or Federal agency to any person other than the individual who is the subject of such data, unless—

"(A) such person to whom such personal data was made available or disclosed requires such data in order to carry out the purposes of this title;

"(B) such personal data is made available or disclosed in response to a demand for such data made by means of compulsory legal process; or

"(C) the informed written consent of the individual who is the subject of such data has been obtained.

"(2) Data collected by the Secretary pursuant to this title that is not personal data shall be made available to bona fide researchers and policy analysts (including the Congress) for the purposes of assisting in the conduct of studies respecting health personnel.

"NONINTERFERENCE WITH ADMINISTRATION OF INSTITUTIONS

"SEC. 710. Nothing contained in this title shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any direction, or supervision of, or control over, or impose any requirement or condition with respect to the personnel, curriculum, methods of instruction, or administration of any institution.

"FINANCIAL DISTRESS GRANTS

"SEC. 711. (a) The Secretary may make grants to, and enter into contracts with, a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health that is in serious financial distress for the purposes of assisting such school to—

"(1) meet the costs of operation;

"(2) meet applicable accreditation requirements if such school has a special need to be assisted in meeting such requirements; or

"(3) carry out appropriate operational, managerial, and financial reforms.

"(b) Any grant or contracts under this section may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree to—

"(1) disclose any financial information or data necessary to determine the sources or causes of such school's financial distress;

"(2) conduct a comprehensive cost analysis study in cooperation with the Secretary; and

"(3) carry out appropriate operational, managerial, and financial reforms including the securing of increased financial support from State or local governmental units or the increasing of tuition.

"(c) In the case of a school that has received a grant or contract under this section in any fiscal year, the amount granted to such school under this section in any subsequent fiscal year may not exceed 75 percent of the amount granted to such school under this section in any fiscal year preceding such subsequent fiscal year. No school may receive a grant under this section if such school has previously received support for three or more years under this section or under section 788(b) (as it existed prior to October 1, 1980).

"(d) For the purpose of making grants and entering into contracts to carry out this section, there are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, and for each of the three succeeding fiscal years.

"ADVANCED FINANCIAL DISTRESS GRANTS

"SEC. 712. (a) The Secretary may make grants to, and enter into contracts with, a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatory, pharmacy, or public health for the purposes of meeting the costs of operation and of appropriate operational, managerial, and financial reforms if such school is in serious financial distress and has previously received grant support under section 711 or under section 788(b) (as it existed prior to October 1, 1980).

"(b) No school may receive a grant or contract under this section unless—

"(1) the school has submitted to the Secretary a plan providing for the school to achieve financial solvency within five years and has agreed to carry out such plan;

"(2) such plan has been reviewed by a panel selected by the Secretary and consisting of three experts in the field of financial management who are not directly affiliated to the school or the Federal Government; and

"(3) the Secretary determines, after consultation with such panel, that such plan has a reasonable likelihood of achieving success.

"(c) The panel described in subsection (b)(2) shall be appointed by the Secretary within 30 days after the date of receipt of the school's plan and shall be dissolved no later than 45 days after the panel's recommendation has been transmitted to the Secretary. Members of the panel shall be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which they perform duties.

"(d) No school may receive a grant or contract under this section unless in the same year the school shall have received, or have a legally binding commitment to receive, a grant or contract from a State or local government or combination thereof for the exclusive purpose of alleviating such school's financial distress. Such grant or contract from a State or local government or combination thereof shall, in the first year of any support under this section, exceed any grant made in the preceding year by such State or local government by an amount equal to or greater than the amount of the proposed grant or contract under this section. In subsequent years of support under this section, such grant or contract from a State or local government or combination thereof shall exceed any grant made by such State or local government or combination thereof in the year prior to the first year of support under this section by an amount equal to or greater than the amount of the grant or contract under this section for such years.

"(e) No school may receive support under this section for more than five years. No grant or contract for support under this section shall be in an amount greater than (1) 75 percent in the third year, (2) 50 percent in the fourth year, and (3) 25 percent in the fifth year, of the average annual amount received in the first two years of grant or contract support under this section.

"(f) An application for a grant or contract under this section shall contain or be supported by assurances that the applicant will, in carrying out its function as a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health, as the case may be, expend during the fiscal year for which such grant is sought an amount of funds from non-Federal sources (other than funds for construction and the grant or contract referred to in subsection (d)) at least as great as the average annual amount of funds from non-Federal sources expended by such applicant in the preceding two years.

"(g) For the purpose of making grants and entering into contracts to carry out this section, there are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981 and for each of the succeeding three fiscal years.

"START-UP AND CONVERSION ASSISTANCE GRANTS

"SEC. 713. (a)(1) For the purposes of meeting national or regional needs for veterinarians, optometrists, podiatrists, or public health personnel, the Secretary may make a grant to a new school of veterinary medicine, optometry, podiatry or public health which begins instruction after July 1, 1980. No school may receive a grant under this subsection unless the number of full-time students enrolled in its first school year of operation will exceed twenty-three.

"(2) The amount of any grant under this subsection may not exceed the following:

"(A) In the year preceding the first year in which such school has students enrolled, an amount equal to the product of $10,000 and the number of full-time students the Secretary estimates will enroll in such school in such first year.

"(B) In the first year in which such school has students enrolled, an amount equal to the product of $10,000 and the number of full-time students enrolled in such school in such year.

Estimates of the number of full-time students enrolled in a school may be made on the basis of assurances provided by the school.

"(3) The Secretary shall give priority in the award of grants under this subsection to applicants for whom the receipt of such grant would facilitate the acceleration of the date upon which instruction would begin or increase the number of students enrolled in the entering class. The Secretary shall also give priority to applicants who will, by virtue of an affiliation with one or more existing health professions institutions, be able to make use of existing facilities and resources, including in the case of a new school of podiatry the use of the basic sciences faculty of a school of medicine or osteopathy.

"(4) The Secretary shall give special consideration to any application submitted by a school for a grant under this subsection if—

"(A) such school will be located in a health manpower shortage area (designated under section 332); or

"(B) such school is a school of public health, optometry, veterinary medicine, or podiatry that will be located in a State that has no other such school.

"(5) For purposes of this subsection, any school of public health, optometry, veterinary medicine, or podiatry shall be considered a new school for any year if such year is—

"(A) the year preceding the first year in which such school has students enrolled;

"(B) the first year such school has students enrolled; and

"(C) the year following the first year such school has students enrolled.

"(6) Any school that first received a start-up assistance grant under the authority of section 788(a) (as it existed prior to October 1, 1980) and would have reasonably expected to have received subsequent grants under such authority in fiscal year 1981, 1982, or 1983, shall be eligible to receive such grants under this subsection on the same terms and conditions as were contained in section 788(a) (as it existed prior to October 1, 1980).

"(b)(1) The Secretary may make a grant to a public or nonprofit private two-year school of medicine that intends to become a school accredited to grant the degree of doctor of medicine. The amount of the grant to a school under this subsection shall be equal to the product of $25,000 and the number of third-year students that will be initially enrolled in such school. No school may receive more than one grant under this subsection nor receive a grant under this subsection during any fiscal year in which such school receives support under section 711 or 712.

"(2) No grant may be made under this subsection unless an application therefor has been submitted before October 1, 1981 and the school enrolls third-year students not later than the academic year beginning in the fiscal year ending September 30, 1983. A grant under this subsection shall be made available for expenditure in the school year preceding the year of initial enrollment of third-year students in such school and shall remain available for not more than 36 months. No grant may be made under this subsection unless the school for which the application is submitted will be affiliated with an accredited hospital in the fiscal year for which such grant is made.

"(3) No school may receive a grant under this subsection unless in the same year as such grant is received, the school has received or has a legally binding commitment to receive a grant or contract from a State or local government or a combination thereof for the exclusive purpose of converting from a two-year school to a degree-granting school. Such grant or contract from a State or local government shall exceed the amount of any grant or contract made in the preceding year by such State or local government by an amount equal to or greater than the amount of the proposed grant under this subsection.

"(c) For the purpose of making grants to carry out this section, there are authorized to be appropriated $4,000,000 in the fiscal year ending September 30, 1981 and in each of the succeeding three fiscal years.

"Part B—Student Assistance

"Subpart I—Student Loans

"ESTABLISHMENT OF LOAN PROGRAM

"Sec. 715. The Secretary shall establish a Federal program of student loan insurance and interest payments for students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, nursing (including advanced training programs), and public health. Loans made by eligible lenders in accordance with this subpart shall be insurable by the Secretary regardless of whether such loans are made from funds fully owned by the lender or from funds held by the lender in a trust or similar capacity and available for such loans.

"ELIGIBILITY OF STUDENT BORROWERS AND TERMS OF FEDERALLY INSURED LOANS

"Sec. 716. (a) A loan to a student made by an eligible lender shall be insurable under the provisions of this subpart only if such loan is made to a student who—

"(1) has been accepted for full-time enrollment at an eligible institution or is a full-[illegible] student at an eligible institution, and is a student in good standing at such institution as determined by such institution;

"[illegible] has agreed to utilize all funds received under such loan solely for tuition and other reasonable educational and living expenses, as determined by such student's school; and

"(3) in the case of a pharmacy student, has satisfactorily completed two years of training.

"(b) A loan to a student made by an eligible lender shall be insurable under the provisions of this subpart only if evidenced by a note or other written agreement that—

"(1) is made without security or endorsement, except that if the borrower is a minor and such note or other written agreement executed by him would not, under the applicable law, create a binding obligation, an endorsement may be required;

"(2) except as otherwise provided in this subsection, provides for repayment of the principal amount of the loan in installments over a period of not less than 10 years (unless repaid at an earlier date at the borrower's option) nor more than 15 years beginning not later than 12 months after the date on which the borrower ceases to be covered by the provisions of paragraph (4);

"(3) includes provisions relating to repayment by the borrower in the event of default in the payment of interest or other defaults by the borrower;

"(4) provides that periodic installments of principal need not be paid, but interest shall accrue and be paid, during any period during which the borrower is—

"(A) pursuing a full-time course of study at any eligible institution (or at an institution defined by section 435 (b) of the Higher Education Act of 1965);

"(B) a participant in an accredited internship or residency program (not to exceed three years);

"(C) a member of the Armed Forces of the United States or of the National Health Service Corps (not to exceed three years); or

"(D) in service as a full-time volunteer pursuant to the Peace Corps Act or title I of the Domestic Volunteer Service Act of 1973 (not to exceed three years);

and any such period shall not be included in determining the 15-year period provided in paragraph (2) above.

"(5) provides for interest on the unpaid principal balance of the loan at a yearly rate, not to exceed the applicable maximum rate on a national, regional, or other appropriate basis, which interest shall be compounded not more frequently then semiannually and payable in installments over the period of the loan;

"(6) provides that payment of any interest otherwise payable—

"(A) before the beginning of the repayment period;

"(B) during any period described in paragraph (4); or

"(C) during any other period of forbearance of payment of principal,

may be deferred until the date upon which repayment of the first installment of principal falls due or the date repayment of principal is required to resume (whichever is applicable), and further provides that, on such applicable date, the amount of the interest which has so accrued may be added to the principal for the purposes of calculating a repayment schedule; and

"(7) entitles the borrower to accelerate repayment of the whole or any part of the loan without penalty.

"(c) For the purpose of subsection (b)(5), the maximum rate of interest on the unpaid balance of the loan, including interest payments deferred pursuant to subsection (b)(6), may not exceed the lesser of—

"(1) the average of the bond equivalent rates of the ninety-one-day Treasury bills auctioned for the previous quarter, plus 3.5 percent, the result percent rounded upward to the nearest one-eighth of one percent; or

"(2) 18 percent per annum.

"(d) No provision of any law of the United States (other than subsections (b)(5) and (c) of this section) or of any State that limits the rate or amount of interest payable on loans shall apply to a loan insured under this subpart.

"(e) Nothing in this section shall be construed to preclude the lender and the borrower, by mutual agreement, from consolidating all of the borrower's debts into a single instrument, except that the portion of such debt that is insured under this subpart shall not be consolidated on terms less favorable to the borrower than if no consolidation had occurred.

"(f) During any year in which repayment of interest is not deferred pursuant to subsection (b)(6), the total of interest payments made by a borrower during such year shall not be less than the annual interest (less interest payments under section 718, if any) on the outstanding principal of all loans to such borrower that are insured under this subpart.

"[illegible] LOAN INSURANCE AND INTEREST PAYMENTS FUND

"Sec. 717. (a) There is hereby established a student loan insurance and interest payments fund (hereinafter in this part referred to as the "fund") which shall be available without fiscal year limitation for making interest payments as specified in section 718 and for making payments in connection with the default of loans insured under this subpart. All amounts received by the Secretary, including receipts, earnings, or proceeds derived from any claim or other assets acquired in connection with operations under this subpart, and any other moneys, property, or assets derived from operations in connection with this section, shall be deposited in the fund. All interest payments and payments in connection with the default of loans insured under this subpart shall be paid from the fund. Moneys in the fund not needed for current operations under this section may be invested in bonds or other obligations guaranteed as to principal and interest by the United States.

"(b) If at any time the sums in the fund are insufficient to make interest payments or payments in connection with the default of any loan insured under this subpart, the Secretary may issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriation Acts. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued hereunder and he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under that Act, as amended, are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made from such fund.

"INTEREST PAYMENTS

"Sec. 718. (a) In the case of a borrower described in subsection (b), the Secretary shall, during periods described in subsection (c), pay to the holder of such borrower's loan insured under this subpart and for and on behalf of the borrower who received such loan an amount that is the excess of—

"(1) the amount that is the total annual interest on the unpaid principal amount of the loan (including interest payments deferred pursuant to section 716(b)(6)) over;

"(2) the amount that is the interest on such unpaid principal amount of the loan computed at a rate of seven percent (such amount to remain the responsibility of the borrower but payment of which may be deferred under section 716(b)(6)).

"(b) The Secretary shall make interest payments under subsection (a) to the holder of the loan insured under this subpart (for and on behalf of the borrower) only if at the time the loan was made the eligible institution at which the borrower was enrolled certified in writing to the Secretary that the borrower had a demonstrated financial need (as determined by such institution) for such loan.

"(c)(1) The Secretary shall make interest payments under subsection (a) to the holder of the loan insured under this subpart (for and on behalf of the borrower) only during periods—

"(A) not to exceed five years, when the borrower is enrolled in an eligible institution on a full-time basis and is in good standing at such institution, as determined by the institution;

"(B) not to exceed two years, when the borrower who is a graduate of a school of veterinary medicine, optometry, pharmacy, podiatry, public health, or nursing is a full-time participant in an accredited internship or residency program or other accredited program of advanced training;

"(C) not to exceed three years, when the borrower who is a graduate of a school of medicine, osteopathy or dentistry is a full-time participant in an accredited internship or residency in general internal medicine, general pediatrics, family medicine, general practice, preventive medicine, preventive dentistry, occupational medicine, physical and rehabilitative medicine or dentistry, general dentistry, or general pedodontics;

"(D) not to exceed three years, when the borrower receives advanced training as part of a research fellowship (such as the National Research Service Awards authorized by section 472 of this Act);

"(E) not to exceed three years, when the borrower is providing clinical or preventive health care services for a Federal, State, or local government agency as—

"(i) part of a service scholarship contract (such as the service scholarships authorized under Part D of this title);

"(ii) a full-time member of the Armed Forces of the United States; or

"(iii) a full-time volunteer under the Peace Corps Act or title I of the Domestic Volunteer Service Act of 1973;

"(F)(i) not to exceed two years, when the borrower practices primary or preventive health care in any area; or

"(ii) not to exceed five years, when the borrower practices primary or preventive health care in a health manpower shortage area (designated under section 332); and

"(G) not to exceed five years, when the borrower is performing biomedical research on a greater than half-time basis as part of a full-time research and teaching position as part of the faculty or staff of a health professions school, non-profit biomedical research institute, or Federal biomedical research institute.

"(2) In no case shall interest payments made pursuant to this subsection be paid for and on behalf of any borrower more than fifteen years after the date of the first loan made to such borrower insured under this subpart.

"(d) The Secretary may not approve an application for interest payments under this section unless he determines that the terms, conditions, security (if any), and schedule any amount of repayments with respect to the loan are sufficient to protect the financial interest of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed the maximum rate set by section 716(c).

"(e) If the Secretary determines to make interest payments on a loan insured under this subpart, the holder of a loan with respect to which payments are required to be made under this section shall be deemed to have a contractual right, as against the United States, to receive from the Secretary the portion of interest for which the United States is obligated. The Secretary shall pay such portion of the interest to the holder of the loan on behalf of and for the account of the borrower at such times as may be specified in regulations.

"LIMITATIONS ON LOANS AND LOAN INSURANCE

"Sec. 729. (a) The total amount of the loans made to a student in any academic year or its equivalent (as determined by the Secretary) that may be covered by Federal loan insurance under this subpart may not exceed $30,000 in the case of a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry, $12,500 in the case of a student enrolled in a school of pharmacy or public health, and $8,000 in the case of a student enrolled in a school of nursing. The aggregate insured unpaid principal amount for all such insured loans made to any borrower shall not at any time exceed $80,000 in the case of a borrower enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry, $50,000 in the case of a borrower enrolled in a school of pharmacy, $25,000 in the case of a borrower enrolled in a school of public health, and $30,000 in the case of a borrower enrolled in a school of nursing.

"(b) The insurance liability on any loan insured under this subpart shall be 100 percent of the unpaid balance of the principal amount of the loan plus interest. The full faith and credit of the United States is pledged to the payment of all amounts that may be required to be paid under the provisions of this subpart.

"APPROPRIATIONS

"Sec. 730. (a) For the purpose of carrying out this subpart there are authorized to be appropriated $30,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, $60,000,000 for the fiscal year ending 1983, and $60,000,000 for the fiscal year ending September 30, 1984, to the student loan insurance and interest payment fund, and for fiscal years thereafter, such sums as may be necessary to provide interest payments and loan insurance and pay defaults on loans insured under the authority of this subpart prior to October 1, 1984 and to insure new loans as specified in section 731(a). Sums appropriated under this subpart shall remain available until expended.

"SCOPE AND DURATION OF FEDERAL LOAN PROGRAMS

"Sec. 731. (a) The total principal amounts of new loans made and installments paid pursuant to lines of credit to borrowers covered by Federal loan insurance under this subpart shall not exceed $250,000,000 for the fiscal year ending September 30, 1981, $300,000,000 for the fiscal year ending September 30, 1982, $350,000,000 for the fiscal year ending September 30, 1983, and $400,000,000 for the fiscal year ending September 30, 1984. Thereafter, Federal loan insurance pursuant to this subpart may be granted only for loans made (or for loan installments paid pursuant to lines of credit) to enable students who have obtained prior loans insured under this subpart to continue or complete their educational program. No insurance may be granted for any loan made or installment paid after September 30, 1986.

"(b) The Secretary may, if necessary to assure an equitable distribution of the benefits of this subpart, assign, within the maximum amounts specified in subsection (a), Federal loan insurance quotas applicable to schools, eligible lenders, or to States or areas, and may from time to time reassign unused portions of such quotas.

"(c) The Student Loan Marketing Association, established under part B of title IV of the Higher Education Act of 1965, is authorized to make advances on the security of loans insured under this subpart, or purchase, service, sell, or otherwise deal in such loans.".

LOAN FORGIVENESS; SPECIAL PROJECTS

Sec. 106. Title VII is amended by inserting the following after section 731:

"Subpart II—Loan Forgiveness

"GENERAL

"Sec. 737. (a) The Secretary shall establish a Federal program of loan forgiveness payments to discharge all or part of the loan liabilities of individuals who are students, graduates, or former students of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy.

"(b) Loan forgiveness payments as provided in subsection (a) shall apply only to loans—

"(1) incurred by individuals while enrolled as full-time students in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy; and

"(2) made under subpart I of this part, part B of title IV of the Higher Education Act of 1965, subpart I of part C of title VII of this Act (as it existed prior to October 1, 1980), or subpart II of part C of title VII of this Act (as it existed prior to October 1, 1980).

"STUDENT LOAN FORGIVENESS FUND

"Sec. 738. (a) There is hereby established a student loan forgiveness fund (hereinafter referred to as the 'fund') which shall be available without fiscal year limitation to the Secretary for making loan forgiveness payments in accordance with the priorities established by section 739. All amounts received by the Secretary pursuant to section 739A shall be deposited in the fund. Sums in the fund not needed for current operations may be invested in bonds or other obligations guaranteed as to principal and interest by the United States and may be expended in future years.

"(b) The Secretary shall not, in making loan forgiveness payments under this subpart or in making commitments to make such payments, expend any sums from the fund that are not currently available in such fund or make commitments to expend sums that will not be available before the end of the fiscal year.

"LOAN FORGIVENESS

"Sec. 739. (a) To the extent sums are available in the fund in any fiscal year, the Secretary may make loan forgiveness payments to discharge all or part of the loan liability on loans of individuals as provided in section 737(b) according to priorities set out in subsection (b) of this section.

"(b) The Secretary shall make loan forgiveness payments, as money is available and in the following priority order, to individuals who—

"(1) die or become permanently and totally disabled (as determined in accordance with regulations prescribed by the Secretary);

"(2) completed their first year exams at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry but failed to be advanced to the second year at such school and upon any subsequent attempt to retake the first year courses or exams were unsuccessful in achieving such advancement; and

"(3) entered into loan agreements that were governed by section 755(c), 741(f), or 741(i) (as such sections were in effect prior to October 1, 1980), and who subsequently met or currently meet the eligibility criteria in such sections but have not received loan forgiveness.

"(c)(1) No loan forgiveness payments made under subsection (b)(2) shall exceed the amount of nonreimbursable tuition and fees charged the student by the school.

"(2) Loan forgiveness payments under subsection (b)(2) may cover any loans made to an individual to enable such individual to retake the first year courses if, as a result, the individual does not succeed in advancing to the second year.

"(3) The Secretary may commit loan forgiveness payments but shall not expend such payments for any individual under subsection (b)(2) unless and until the school at which such individual was enrolled provides assurances that such individual cannot reasonably be expected to resume studies at such institution within five years following the date upon which such individual terminated such studies.

"(4) If at any time within five years following the date upon which any individual terminated his studies in an institution and was provided loan forgiveness payments under the terms of subsection (b)(2), such individual rematriculates in such institution or an institution providing a comparable degree, and such individual advances to the second year, the Secretary shall reinstate the original loan obligation.

"(d)(1) Loan forgiveness payments under subsection (b)(3) shall not exceed the amounts to which the individual would have been entitled if sections 735(e), 741(f), and 741(i) (as such sections were in effect prior to October 1, 1980), were still in effect on the date of such payments.

"(2) If insufficient sums are available to provide loan forgiveness payments under subsection (b)(3) to all qualified individuals, the Secretary shall prorate whatever sums are available to provide that all qualified individuals receive the same percentage of the amount otherwise due such individuals under paragraph (1).

"(e)(1) If at the end of any fiscal year there are sums remaining in the fund that the Secretary does not reasonably expect to need for loan forgiveness payments within the next fiscal year, the Secretary may use such sums to enter into a written contract with a borrower on whose behalf a loan has been insured under subpart I under which the Secretary agrees to assume the obligation of paying an amount, not to exceed $500 per month for not more than 24 months, toward the principal and interest due on such loan and the borrower agrees to serve in a full-time private clinical practice in a health manpower shortage area (designated under section 332) for a continuous period of not less than 12 months. Such service shall commence no later than 12 months after the date of the agreement between the Secretary and the borrower.

"(2) If an individual who has entered into a written contract under paragraph (1), for any reason breaches his contract obligations with respect to serving in a health manpower shortage area for the period specified in the contract, such individual shall not be entitled to further monthly payments under such contract and the United States shall be entitled to recover from such individual any monthly payments made by the United States for months that such individual did not fulfill such contractual obligation. In addition to recovery of such monthly payments, the United States shall be entitled, within six months after the date of the breach of such contract obligations, to receive from such individual the amount of $1,000 as liquidated damages.

"(3) The United States shall not be entitled to recover any damages from an individual under paragraph (2) upon the death of the individual.

"(4) The Secretary shall by regulation provide for—

"(A) the waiver or suspension of any obligation of service, or

"(B) the payment of any or all of the damages to which the United States is entitled under paragraph (2); whenever the Secretary determines that compliance by an individual with the contract is impossible or would involve extreme hardship to the individual and that recovery of such damages with respect to the individual would be unconscionable.

"DISTRIBUTION OF ASSETS OF STUDENT LOAN FUND

"SEC. 729A. (a) After September 30, 1980, and not later than March 31, 1981, each school that established a student loan fund (known as the Health Professions Student Loan Fund) pursuant to section 740 (as such section existed prior to October 1, 1980) shall provide for a capital distribution of the balance of such fund. The distribution of such loan funds by each school shall be as follows:

"(1) The Secretary shall first be paid an amount bearing the same ratio to such balance in such fund at the close of September 30, 1980, as the total amount of the Federal capital contributions to such fund pursuant to section 740(b)(2)(A) (as it existed prior to October 1, 1980) bears to the total amount in such fund derived from such Federal capital contributions and from funds deposited therein pursuant to section 740(b)(2)(B) (as it existed prior to October 1, 1980).

"(2) The remainder of such balance shall be paid to the school.

"(b) After March 31, 1981, each school that established a student loan fund in accordance with section 740 (as it existed prior to October 1, 1980) shall pay to the Secretary, not less often than quarterly, the same proportionate share of amounts received by the school after September 30, 1980, in payment of principal and interest on loans made from the loan fund, as was determined under subsection (a)(1).

"(c) Funds received by the Secretary under this section shall be deposited in the Student Loan Forgiveness Fund established under section 729.

"PART C—SPECIAL PROJECTS

"Subpart I—General

"GENERAL PROVISIONS

"SEC. 730. (a) The Secretary may make grants to, and enter into contracts with, schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, allied health, and public health, graduate programs in health administration, and other eligible entities in order to meet the costs of carrying out special projects as provided in this part.

"(b)(1) In calculating the amount of each special project grant or contract under this part which is made to an eligible school or graduate program, the Secretary shall add to the Federal share of the cost of carrying out such project an amount equal to 20 percent of such Federal share of the cost if the school or program provides assurances to the Secretary that it has met or will meet the applicable conditions specified in section 731.

"(2) If an application for a grant or contract under this part is submitted jointly by more than one school or program, and not all such schools or programs submitting such application provide the assurances required under paragraph (1) in order to receive the additional funds under such paragraph, the Secretary may provide such additional funds to such schools or programs providing such assurances, and deny such additional funds to such schools or programs failing to provide such assurances.

"(3) Such additional funds shall be used for the purpose of supporting any aspect of the educational programs of such schools, and any school receiving such additional funds shall be required to provide assurances that such funds are being used for such purpose.

"(c) Except in the case of applications for continuation awards, the Secretary shall give special consideration for grants and contracts under this part to applications made by applicants who would not otherwise receive a grant or contract under this part for the same fiscal year.

"CONDITIONS

"SEC. 731. (a)(1) No school or graduate program shall be eligible to receive the additional funds specified in section 730(b)(1), unless such school or graduate program, as part of its application for a grant or contract under this part, provides assurances that it has met (or will meet if the application is approved) the conditions specified in this section applicable to such school or graduate program. The willingness or failure of any school or graduate program to provide such assurances shall not affect whether such school or graduate program receives a grant or contract under this part.

"(2) For purposes of this section, a reference to a year class of students is a reference to students enrolled in such class for the first time.

"(b) To be eligible for the additional funds specified in section 730(b)(1), a school of medicine or osteopathy shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet three of the following conditions:

"(1) the school provides, or plans to provide with 12 months, at least one required course, or some comparable amount of instruction as part of other required courses, in health policy and health care economics,

"(2) the school's tuition and fees for both in-State and out-of-State students are not more than [illegible] percent greater than such school's tuition and fees for such students in the previous school year,

"(3)(A) the school provides, or plans to provide, within 12 months, at least two courses, or some comparable amount of instruction in other courses, in any of the following areas: geriatrics, nutrition, occupational medicine, environmental medicine, medical ethics and forensic medicine, and preventive or community medicine (or public health); or

"(B) the school conducts, or plans to conduct within 12 months, a community medical education and screening program (of at least four months duration) designed to either (i) educate and screen the general population for preventable or controllable diseases or conditions, such as high blood pressure and obesity; or (ii) meet the health education needs of a defined special population, such as the handicapped, elderly, indigent, or institutionalized children;

"(4) (A) the school provides, or plans to provide within 12 months, opportunities for students to receive significant clinical training in areas in which medically underserved populations reside or in ambulatory care settings in areas geographically remote from the main site of the teaching facilities of the school; or,

"(B) the school provides, or coordinates with an existing system to provide, or plans to do so within 12 months, a program for the delivery of primary or preventive health care services to an underserved population, such as local prisoners or public nursing home residents; and

"(5) of the school's filled first year positions in direct or affiliated medical or osteopathic residency training programs, the school has, or will have within 12 months at least 65 percent of such positions in general internal medicine, general pediatrics, or family medicine.

"(c) To be eligible for the additional funds specified in section 730 (b) (1), a school of dentistry shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet three of the following conditions:

"(4)(A) the school provides, or plans to provide within 12 months, opportunities for students to receive significant clinical training in areas in which medically underserved populations reside or in ambulatory dental care settings in areas geographically remote from the main site of the teaching facilities of the school; or

"(B) the school provides or coordinates with an existing system to provide, or plans to do so within 12 months, a program for the delivery of primary or preventive dental care services to an underserved population, such as local prisoners or public nursing home residents; and

"(6) of the school's first year positions in direct or affiliated dental specialty programs in excess of the number of such positions that were available on January 1, 1978, the school has, or will have within 12 months, at least seventy percent of such excess positions in general dentistry or pedodontics.

"(d) To be eligible for the additional funds specified in section 780(b)(1), a school of veterinary medicine shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet the following conditions:

"(1) the predominant emphasis of the school's clinical training is the care of food-producing and fibre-producing animals;

"(2) the school's first year student enrollment is the same or greater than the first year student enrollment in the previous school year; and

"(3)(A) at least 15 percent of the enrollment of full-time, first year students in the school is comprised of students who are residents of States in which there are no schools of veterinary medicine; or

"(B) the school provides, or plans to provide within 12 months, at least two courses, or some comparable amount of instruction in other courses, in any of the following areas: toxicology, environmental medicine, health policy and health care economics, laboratory animal medicine, and animal and human nutrition.

"(e) To be eligible for the additional funds specified in section 780(b)(1), a school of optometry shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet three of the following conditions:

"(1) the school's first year student enrollment is the same or greater than the first year student enrollment in the previous school year;

"(2) the school's tuition and fees for both in-State and out-of-State students are not more than 10 percent greater than such school's tuition and fees for such students in the previous school year;

"(3) the school provides, or plans to provide within 12 months, at least two courses, or some comparable amount of instruction in other courses, in any of the following areas: health policy and health care economics, rehabilitative procedures, use of optometric auxiliary, geriatrics, and public health and disease prevention;

"(4)(A) the school has since July 1, 1980, or will within 12 months of the submission of an application for a grant or contract under this part, increased the first year student enrollment by 5 percent or 5 students (whichever is less) over first year student enrollment in the previous school year and has agreed to maintain such increased enrollment level for at least three academic years; or

"(B) at least 20 percent of the enrollment of full-time, first year students in the school (or 40 percent if the applicant is a nonprofit private school of optometry) is comprised of students who are residents of States in which there are no schools of optometry; and

"(5)(A) the school provides, or plans to provide within 12 months, opportunity for students to receive significant clinical training in areas in which medically underserved populations reside or in ambulatory eye care settings in areas geographically remote from the main site of the teaching facilities of the school; or

"(B) the school conducts, or plans to conduct within 12 months, a community vision care education and screening program (of at least four months duration) designed to either (i) educate and screen the general population regarding preventable or controllable eye diseases or conditions; or (ii) meet the eye care education needs of a defined special population, such as the handicapped, elderly, indigent, or institutionalized children; or

"(C) the school provides or coordinates with an existing system to provide, or plans to do so within 12 months, a program for the delivery of primary eye care or preventive eye care services to an underserved population, such as local prisoners or public nursing home residents.

"(f) To be eligible for the additional funds specified in section 780(b)(1), a school of podiatry shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet three of the following conditions:

"(1) the school's first year student enrollment is the same or greater than the first year student enrollment in the previous school year;

"(2) the school's tuition and fees for both in-State and out-of-State students are not more than 10 percent greater than such school's tuition and fees for such students in the previous school year;

"(3) the school provides, or plans to provide within 12 months, at least two courses, or some comparable amount of instruction in other courses, in any of the following areas: health policy and health care economics, rehabilitative procedures, use of podiatric auxiliaries, geriatrics, and public health and disease prevention;

"(4)(A) the school has since July 1, 1980, or will within 12 months of the submission of an application for a grant or contract under this part, increased the first year student enrollment by 5 percent or 5 students (whichever is less) over first year student enrollment in the previous school year, and has agreed to maintain such increased enrollment level for at least three academic years; or

"(B) at least 40 percent of the enrollment of full-time, first year students in the school is comprised of students who are residents of States in which there are no schools of podiatry; and

"(5)(A) the school provides, or plans to provide within 12 months, opportunity for students to receive significant clinical training in areas in which medically underserved populations reside or in ambulatory foot care settings in areas geographically remote from the main site of the teaching facilities of the school; or

"(B) the school conducts, or plans to conduct within 12 months, a community foot care education and screening program (of at least four months duration) designed to either (i) educate and screen the general population relating to preventable or controllable foot diseases or conditions; or (ii) meet the foot care education needs of a defined special population, such as the handicapped, elderly, indigent, or institutionalized children; or

"(C) the school provides or coordinates with an existing system to provide, or plans to do so within 12 months, a program for the delivery of primary foot care or preventive foot care services to an underserved population, such as local prisoners or public nursing home residents.

"(g) To be eligible for the additional funds specified in section 780(b)(1), a school of pharmacy shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met, or will meet the following conditions:

"(1)(A) the school provides, or plans to provide within 12 months, at least two courses, or some comparable amount of instruction in other courses, in any of the following areas: health policy and health care economics, public health and disease prevention, nutrition, and geriatrics; or

"(B) the school's tuition and fees for both in-State and out-of-State students are not more than 10 percent greater than such school's tuition and fees for such students in the previous school year; and

"(2) the school requires each student who is enrolled in the school to participate in a training program in clinical pharmacy which, at a minimum, shall include—

"(A) an inpatient and outpatient clerkship experience in a hospital, extended care facility, or other clinical setting;

"(B) interaction with physicians and other health professionals;

"(C) training in the counseling of patients with regard to reactions to, and the appropriate use of, drugs; and

"(D) training in drug information retrieval and analysis in the context of actual patient problems.

"(h) To be eligible for the additional funds specified in section 780(b)(1), a school of public health or graduate program in health administration shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, such school has met or will meet the following conditions:

"(1) the school or graduate program's first year student enrollment is the same or greater than the first year student enrollment in the previous school year;

"(2)(A) the school or graduate program provides, or plans to provide within 12 months, a range of courses during evening and weekend hours such that students can matriculate on a part-time basis and receive a degree while working; or

"(B) the school or graduate program provides, or plans to provide within 12 months, a program of continuing education for health professionals who are involved, full-time or part-time, in public health or health administration and for graduates of a school of public health or graduate program in health administration; or

"(C) the school or graduate program requires, or plans to require within 12 months, each student who is enrolled in the school full-time in a course of study of more than one year's duration, to participate in a part-time clerkship or internship in a public health agency, or a hospital, extended care facility, or other facility where preventive or clinical health care is provided.

"(i) To be eligible for the additional funds specified in section 780(b)(1), a school of allied health (as defined by section 700(8)) shall provide assurances that in the school year starting immediately before the fiscal year in which the grant would be made, it provides, or plans to provide within 12 months, an opportunity for students enrolled in such school to participate in and receive credit for a course in health policy and health care economics, such course to be offered by such school directly, by agreement with another local health professions school, or by other arrangement, so long as such arrangement does not, by reason of traveltime or cost, discourage students from enrolling in such course.

"Subpart II—Graduate Training and Specialty Distribution

"GRANTS FOR TRAINING IN GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND FAMILY MEDICINE

"Sec. 785. (a) The Secretary may make grants to and enter into contracts with schools of medicine and osteopathy to assist in meeting the costs to such schools of providing projects to—

"(1) plan, develop, and operate or maintain approved residency training programs in internal medicine, pediatrics, or family medicine which emphasize the training of residents for the practice of general internal medicine or general pediatrics or family medicine;

"(2) plan, develop, and operate or maintain programs (that may be structured differently than residency training programs) to train or retrain practicing physicians to practice general internal medicine, general pediatrics, or family medicine;

"(3) plan, develop, and operate or maintain programs (that may be structured differently than residency training programs) for the training of physicians who plan to teach in general internal medicine, general pediatrics, and family medicine training programs; and

"(4) provide financial assistance (in the form of traineeships and fellowships) to residents and practicing physicians who are in need of financial assistance and who are participants in a program described in paragraphs (1), (2), and (3), and who plan to specialize, teach, or work in the practice of general internal medicine, general pediatrics, or family medicine.

"(b) A school may apply for a grant or contract under this section for, or on behalf of, an affiliated training program or affiliated hospital, such program or hospital having primary control over the operation and curriculum content of the training to be provided.

"(c) There are authorized to be appropriated to carry out the provisions of this section $80,000,000 for the fiscal year ending September 30, 1981, $85,000,000 for the fiscal year ending September 30, 1982, $90,000,000 for the fiscal year ending September 30, 1983, and $95,000,000 for the fiscal year ending September 30, 1984.

"GRANTS FOR TRAINING IN GENERAL PRACTICE OF DENTISTRY

"Sec. 736. (a) The Secretary may make grants to, and enter into contracts with, schools of dentistry to assist in meeting the costs to such schools of providing projects to—

"(1) plan, develop, and operate or maintain an approved residency program in the general practice of dentistry; and

"(2) provide financial assistance (in the form of traineeships and fellowships) to residents in such program in need of financial assistance and who plan to specialize in the practice of general dentistry.

"(b) There are authorized to be appropriated to carry out the provisions of this section $6,000,000 for the fiscal year ending September 30, 1981, $7,500,000 for the fiscal year ending September 30, 1982, $8,500,000 for the fiscal year ending September 30, 1983, and $9,500,000 for the fiscal year ending September 30, 1984.

"PROJECT GRANTS FOR DEPARTMENTS OF FAMILY MEDICINE

"Sec. 737. (a) The Secretary may make grants to schools of medicine and osteopathy to assist in meeting the costs to such schools of providing projects to establish and maintain or improve academic administrative units (which may be departments, divisions, or other units) to provide clinical instruction in family medicine.

"(b) The Secretary shall not approve an application for a grant under subsection (a) unless such application contains assurances that the academic administrative unit with respect to which the application is made—

"(1) will be generally comparable to academic administrative units for other major clinical specialities offered by the applicant with regard to curriculum time, number of faculty, and clinical population served; and

"(2) has or plans to have within 12 months, a close affiliation with a three year approved or provisionally approved residency training program in family medicine or its equivalent (as determined by the Secretary) which shall have the capacity to enroll a total of no less than twelve interns or residents per year.

"(c) There are authorized to be appropriated to carry out the provisions of this section $12,000,000 for the fiscal year ending September 30, 1981, $13,000,000 for the fiscal year ending September 30, 1982, $14,000,000 for the fiscal year ending September 30, 1983, and $15,000,000 for the fiscal year ending September 30, 1984.

"GRANTS FOR TRAINING IN PREVENTIVE MEDICINE AND PHYSICAL AND REHABILITATIVE MEDICINE

"Sec. 738. (a) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, and public health to assist in meeting the costs to such school of providing projects to—

"(1) plan, develop, and operate or maintain a physician residency training program in preventive medicine (including environmental medicine and occupational medicine); and

"(2) provide financial assistance (in the form of traineeships and fellowships) to residents in any such program in need of financial assistance and who plan to specialize or work in preventive medicine (or public health or environmental medicine or occupational medicine).

"(b) The Secretary may make grants to and enter into contracts with schools of medicine and osteopathy to meet the costs to such schools of providing projects to—

"(1) plan, develop, and operate or maintain a physician residency training program in physical medicine and rehabilitation; and

"(2) provide financial assistance (in the form of traineeships and fellowships) to residents in any such program in need of financial assistance and who plan to specialize or work in physical medicine and rehabilitation.

"(c) There are authorized to be appropriated to carry out the provisions of this section $7,000,000 for the fiscal year ending September 30, 1981, $8,500,000 for the fiscal year ending September 30, 1982, $10,000,000 for the fiscal year ending September 30, 1983, and $11,500,000 for the fiscal year ending September 30, 1984.".

SPECIAL PROJECTS; SERVICE SCHOLARSHIPS

Sec. 108. Title VII is amended by inserting the following after section 739:

"Subpart III—Improving Geographic Distribution

"AREA HEALTH EDUCATION CENTERS

"Sec. 740. (a) The Secretary may make grants or enter into contracts with schools of medicine and osteopathy for projects to assist in the planning, development, and operation of area health education center programs.

"(b) An area health education center program shall be a cooperative program of one or more nonprofit or public area health education centers.

"(c)(1) Each school of medicine or osteopathy participating in an area health education center program shall—

"(A) provide for the active participation in such program of individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no such departments) of internal medicine, pediatrics, obstetrics and gynecology, surgery, psychiatry, and family medicine;

"(B) provide that no less than 10 percent of all undergraduate medical or osteopathic clinical education provided by the school is conducted in an area health education center and at locations under the sponsorship of a center; and

"(C) provide for the active participation of at least 2 schools or programs of other health professions (including a school of dentistry if such school is affiliated with the university with which the school of medicine or osteopathy is affiliated) in the educational program conducted in the area served by the area health education center.

(2) At least one medical or osteopathic school participating in each area health education center program shall be responsible for, or conduct, a program for the training of physician assistants (as defined in section 701(8)) or nurse practitioners (as defined in section 822) such program to give special consideration to the enrollment of individuals from, or intending to practice in, the area served by the area health education center.

"(d)(1) Each area health education center shall specifically designate a geographic area or a medically underserved population it will serve, which area or population is in a location remote from the main site of the teaching facilities of the school or schools which participate in the program with such center.

"(2) Each area health education center shall—

"(A) provide for or conduct training in the area served by the center in health education services, including education in nutrition evaluation and counseling;

"(B) assess the health manpower needs of the area served by the center (in coordination with the activities of the local health systems agency or agencies relating to such health manpower needs of the area) and assist in the planning and development of training programs to meet such needs;

"(C) provide for or conduct a medical residency training program in family medicine, general internal medicine, or general pediatrics in which no fewer than six individuals are enrolled in first-year positions in such program;

"(D) provide opportunities for continuing medical education (including education in disease prevention) to all physicians and other health professionals, including allied health personnel, practicing within the area served by the center;

"(E) provide continuing medical education and other support services, to the extent needed, to National Health Service Corps members and to individuals providing services under programs pursuant to section 760 in the area served by the center;

"(F) encourage the utilization of nurse practitioners and physician assistants within the area served by the center and the recruitment of individuals for training in such professions at the participating medical or osteopathic schools;

"(G) arrange and support educational opportunities for medical and other students at health facilities, ambulatory care centers, and health agencies throughout the area served by the center; and

"(H) be advised by an advisory board of which at least 75 percent of the members shall be individuals from the area served by the center including both health service providers and consumers.

Any school which is participating in an area health education center program in which another school has a medical residency training program described in subparagraph (C) that includes such center's area need not provide for or conduct such a medical residency training program.

"(e) The Secretary is authorized to make grants and to enter into contracts with schools of medicine and osteopathy that have cooperative arrangements with area health education centers, for the planning, development, and operation of area health education center programs. In entering into contracts under this subsection the Secretary shall provide that—

"(1) at least 75 percent of the total funds provided to any school shall be expended by an area health education center program in the area health education centers participating in such cooperative arrangement;

"(2) not more than 75 percent of the total operating funds of a program in any year shall be provided by the Secretary; and

"(3) no contract shall provide funds solely for the planning or development of such program for a period of more than two years.

"(f) There are authorized to be appropriated to carry out the provisions of this section $36,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, $44,000,000 for the fiscal year ending September 30, 1983, and $48,000,000 for the fiscal year ending September 30, 1984.

"REMOTE SITE TRAINING

"Sec. 741. (a) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy, to assist such schools in meeting the costs of projects to provide clinical training to students of such schools in areas that are geographically remote from the main site of the teaching facilities of the school and that are in areas in which medically underserved populations reside.

"(b) No grants or contracts under this section shall be made to carry out a project in an area health education center that has received funding under section 740.

"(c) There are authorized to be appropriated to carry out the provisions of this section $6,500,000 for the fiscal year ending September 30, 1981, $7,000,000 for the fiscal year ending September 30, 1982, $8,500,000 for the fiscal year ending September 30, 1983, and $10,000,000 for the fiscal year ending September 30, 1984.

"SUPPORT SERVICES FOR HEALTH PROFESSIONALS PRACTICING IN UNDERSERVED AREAS

"Sec. 742. (a) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, and dentistry to assist such schools in meeting the costs of planning, establishing, and operating projects to provide support services to physicians or dentists practicing in medically underserved areas (designated under section 332). Such support services may include continuing education, relief services, specialist referral services, and placement of students in a preceptorial relationship with the practitioner.

"(b) No grant may be made to or contract entered into with a school under subsection (a)—

"(1) unless the school agrees to provide support services to any physician or dentist who request such services within the medically underserved area proposed to be served, including any physician or dentist who is a member of the National Health Service Corps or a service program assisted under section 752; and

"(2) to carry out activities required to be carried out under section 740.

"(c) Not more than 20 percent of the funds appropriated to carry out this section may be used by the Secretary to fund eligible recipients to carry out research relating to the support needs of practitioners in medically underserved areas, nor shall more than 40 percent of such funds be used to provide continuing education.

"(d) There are authorized to be appropriated to carry out the provisions of this section $5,500,000 for the fiscal year ending September 30, 1981, $7,000,000 for the fiscal year ending September 30, 1982, $8,500,000 for the fiscal year ending September 30, 1983, and $10,000,000 for the fiscal year ending September 30, 1984.

"Subpart IV—Training and Circular Development

"PROGRAMS FOR PHYSICIAN ASSISTANTS, EXPANDED FUNCTION DENTAL AUXILIARIES AND INTERDISCIPLINARY TRAINING

"Sec. 745. (a) (1) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, and dentistry to assist in meeting the costs to such schools of providing projects to—

"(A) plan, develop, and operate or maintain programs for the training of physician assistants (as defined in section 700 (8)); and

"(B) plan, develop, and operate or maintain programs for the training of expanded function dental auxiliaries (as defined in section 700 (6)).

"(2) No grant or contract may be made under this subsection unless the application therefor contains or is supported by assurances that the school receiving the grant or contract has appropriate mechanisms for placing graduates of the training program (with respect to which the application is submitted) in positions for which they have been trained.

"(3) The allowable costs for which a grant or contract under this subsection may be made include costs of preparing faculty members to teach in programs for the training of physician assistants and expanded function dental auxiliaries.

"(b) The Secretary may make grants to any health profession, allied health, or nurse training institution for the development of programs for cooperative interdisciplinary training among schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing, public health, and allied health. Such programs shall emphasize—

"(1) the use of the multiple auxiliary team approach to the delivery of health services;

"(2) the training of physician assistants and nurse practitioners with physicians, the training of expanded function dental auxiliaries with the dentists, and the training of other auxiliaries with other health professionals; and

"(3) the training of physicians, dentists, nurses, optometrists, podiatrists, and other health professionals in the organization, management, and effective utilization of assistants, practitioners, and auxiliaries.

"(c) The implementation of this section shall be consistent with the implementation of section 822.

"(d) There is authorized to be appropriated for grants and contracts under this section $28,000,000 for the fiscal year ending September 30, 1981, $29,000,000 for the fiscal year ending September 30, 1982, $30,000,000 for the fiscal year ending September 30, 1983, and $31,000,000 for the fiscal year ending September 30, 1984.

"PROJECTS AND ADVANCED TRAINEESHIPS FOR ALLIED HEALTH PERSONNEL

"Sec. 746. (a) The Secretary may make grants to and enter into contracts with schools of allied health to assist such schools in meeting the costs of planning, developing, demonstrating, operating, and evaluating projects relating to the following.

"(1) The establishment of regional resource centers for the coordination and management of data and research on the training of allied health personnel in educational institutions and clinical settings.

"(2) The development and implementation of programs to—

"(A) improve the clinical training of allied health personnel;

"(B) demonstrate the utilization of allied health personnel in containing health care costs, and

"(C) develop multiple competency allied health personnel.

"(3) The development and implementation of new or improved curriculum offerings in health promotion and disease prevention, environmental health, geriatrics, nutrition, and public health.

"(4) The establishment or improvement of programs of recruitment, training, and retraining of allied health personnel, emphasizing the needs of medically underserved areas.

"(5) The demonstration of methods of meeting new health services needs without creating new allied health occupations or specialities.

"(b)(1) The Secretary may make grants to schools of allied health to provide traineeships for allied health personnel for advanced training to enable such personnel to teach other allied health personnel or to serve in administrative or supervisory positions.

"(2) Grants shall be limited to such amounts as the Secretary finds necessary to cover the cost of tuition, fees, stipends, and allowances (including travel and subsistence expenses and dependency allowances) for the trainees.

"(c) There are authorized to be appropriated to carry out the provisions of this section $15,000,000 for the fiscal year ending September 30, 1981, $17,000,000 for the fiscal year ending September 30, 1982, $19,000,000 for the fiscal year ending September 30, 1983, and $21,000,000 for the fiscal year ending September 30, 1984.

"PROJECT AND TRAINEESHIPS FOR PUBLIC HEALTH AND HEALTH ADMINISTRATION

"Sec. 747. (a) The Secretary may make grants to schools of public health, graduate programs in health administration, and other educational institutions that provide post-baccalaureate programs in health administration, health planning and health policy analysis in order to assist such schools or programs in—

"(1) meeting the costs of projects to develop new curriculum programs, strengthen, improve, or expand existing curriculum programs, or carry out special projects in—

"(A) biostatistics or epidemiology;

"(B) health administration, health planning, or health policy analysis and planning;

"(C) environmental or occupational health;

"(D) diet and nutrition;

"(E) maternal and child health;

"(F) preventive medicine or dentistry;

"(G) gerontology; or

"(H) techniques for the evaluation of the cost, quality, and effectiveness of organizational structures and technology in the delivery of health care; and

"(2) providing traineeships to students enrolled at such entities at the post-baccalaureate level.

"(b) Grants for traineeships made under subsection (a)(2) shall provide for tuition and fees and such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary. Special consideration in the awarding of such traineeships shall be given to individuals who have at least one year of full-time work experience in health services.

(c) Not less than 80 percent of the funds appropriated to carry out subsection (a) shall be awarded to schools of public health and graduate programs in health administration.

"(d) There are authorized to be appropriated to carry out the provisions of this section $25,000,000 for the fiscal year ending September 30, 1981, $27,000,000 for the fiscal year ending September 30, 1982, $28,000,000 for the fiscal year ending September 30, 1983, and $29,000,000 for the fiscal year ending September 30, 1984.

"CLINICAL TRAINING

"Sec. 748. (a) For the purposes of improving and strengthening the clinical training provided to students in schools of veterinary medicine, optometry, pharmacy and podiatry, the Secretary may make grants to and enter into contracts with such schools to assist in meeting the costs of projects to—

"(1) establish new affiliations and expand existing affiliations with hospitals, ambulatory care centers, and practitioners, in order to provide students with clinical training; and

"(2) develop, establish, strengthen, or expand programs that provide students with clinical training.

"(b) The Secretary shall give special consideration under subsection (a) to applications for a grant or contract under this section for projects that emphasize clinical training in ambulatory settings and office-based settings, and in medically underserved areas.

"(c) In the case of a school of veterinary medicine, the Secretary shall not make a grant under subsection (a) unless such school provides assurances that the grant will not be used to establish, expand, or improve a clinical program which emphasizes care to companion animals.

"(d) There are authorized to be appropriated to carry out the provisions of this section $12,000,000 for the fiscal year ending September 30, 1981, $14,000,000 for the fiscal year ending September 30, 1982, $16,000,000 for the fiscal year ending September 30, 1983, and $18,000,000 for the fiscal year ending September 30, 1984.

"HEALTH POLICY AND HEALTH CARE ECONOMICS

"Sec. 749. (a) The Secretary may make grants to and enter into contracts with schools of medicine osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and allied health to assist in meeting the costs of projects to—

"(1) develop innovative approaches to teaching health professions and allied health students about health policy and health care economics and the relationship between such policy and economics and the work of health care personnel; and

"(2) develop, establish, improve, or expand the curriculum of such schools with regard to health policy and health care economics, including the integration of such policy and economics into the clinical training of students enrolled in such schools.

"(b) There are authorized to be appropriated to carry out the provisions of this section $5,000,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30 1982, $7,000,000 for the fiscal year ending September 30, 1983, and $8,000,000 for the fiscal year ending September 30, 1984.

"CONTINUING EDUCATION

"Sec. 750. (a) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy allied health, and public health, and graduate programs in health administration to assist in meeting the costs of projects to—

"(1) evaluate the effectiveness of current efforts to assure the continuing competency of health professionals and allied health personnel through continuing education;

"(2) assess future needs in the areas of continuing education;

"(3) develop innovative approaches to providing continuing education; and

"(4) provide continuing education programs for health professionals and allied health personnel who are in medically underserved areas or who do not have adequate access to such programs.

"(b) No grant or contract may be made under subsection (a)(4) to carry out any activities which are funded, directly or indirectly, by funds provided pursuant to section 740 or 742.

"(c) The Secretary shall give special consideration under subsection (a) to applications which emphasize the continuing education needs of health professionals who are involved in delivery of primary care.

"(d) There are authorized to be appropriated to carry out the provisions of this section $5,000,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30, 1982, $7,000,000, for the fiscal year ending September 30, 1983, and $8,000,000 for the fiscal year ending September 30, 1984.

"EDUCATIONAL COST

"Sec. 751. (a) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, allied health, and public health, and graduate programs in health administration to assist in meeting the costs of projects to plan, develop, and demonstrate methods of reducing the total cost of education in such schools and such graduate programs without impairing the quality of such education.

"(b) There are authorized to be appropriated to carry out the provisions of this section $5,000,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30, 1982, $7,000,000 for the fiscal year ending September 30, 1983, and $8,000,000 for the fiscal year ending September 30, 1984.

"CURRICULUM DEVELOPMENT

"Sec. 752. (a) For the purposes of improving and strengthening the curriculum of health professions schools, the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy to assist in meeting the costs of projects to plan, develop, and establish courses, or expand or strengthen instruction in the following areas:

"(1) geriatrics;

"(2) diet and nutrition;

"(3) public health and community health education (or disease prevention and health promotion);

"(4) occupational and environmental health;

"(5) physical medicine and rehabilitative procedures;

"(6) toxicology; and

"(7) animal and human nutrition.

"(b) The Secretary may set aside not more than 20 percent of any amounts appropriated to carry out this section to make grants to assist schools to plan, develop, and implement innovative curriculum programs in health areas not specified in subsection (a).

"(c) There are authorized to be appropriated to carry out the provisions of this section $8,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, $10,000,000 for the fiscal year ending September 30, 1983, and $11,000,000 for the fiscal year ending September 30, 1984.

"Subpart V—Student Diversity

"EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

"Sec. 788. (a)(1) For the purpose of increasing health education opportunities for individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary), the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, and allied health and other public or private nonprofit health or educational entities to assist in meeting the costs described in paragraph (2).

"(2) A grant or contract under paragraph (1) may be used by such school or other entity to meet the costs of—

"(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds, for education and training in a health profession or allied health field;

"(B) providing counseling or other services designed to assist such individuals to enter and successfully complete their education at such a school;

"(C) providing, prior to the entry of such individuals into the regular course of education of such school, preliminary education designed to assist such individuals in successfully completing such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education; and

"(D) publicizing existing sources of financial aid available to students in the education program of such a school and to students who are undertaking training necessary to qualify them to enroll in such a program.

"(b) Not more than 20 percent of the funds appropriated under this section may be used for grants or contracts to entities that are not schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, or allied health. Not more than 5 percent of the funds appropriated under this section may be used for grants or contracts having the primary purpose of informing individuals about the existence and general nature of health careers.

"(c) There are authorized to be appropriated to carry out the provisions of this section $26,000,000 for the fiscal year ending September 30, 1981, $27,000,000 for the fiscal year ending September 30, 1982, $28,000,000 for the fiscal year ending September 30, 1983, and $29,000,000 for the fiscal year ending September 30, 1974.

"PART D—SERVICE SCHOLARSHIPS

"Subpart I—Grants to States for Service Scholarships

"GENERAL

"Sec. 760. (a) For the purposes of assisting States in meeting the health care delivery needs of health manpower shortage areas, the Secretary shall make grants to States to assist in the establishment or expansion of State service scholarship programs modeled on the National Health Service Corps Scholarship programs modeled on the National Health Service Corps Scholarship Program.

"(b) Grants under this subpart shall be made solely to fund the cost of service scholarships provided by a State service scholarship program.

"(c) The Secretary shall report to Congress on March 1 of each year regarding—

"(1) the allocation of funds for service scholarships to each State;

"(2) the number of service scholarship awards made by each State; and

"(3) the distribution of such service scholarships by each State among the health professions.

"(d) To carry out the purposes of this section there are authorized to be appropriated $40,000,000 in the fiscal year ending September 30, 1981, $50,000,000 in the fiscal year ending September 30, 1982, $60,000,000 in the fiscal year ending September 30, 1983, and $70,000,000 in the fiscal year ending September 30, 1984.

"STATE SERVICE SCHOLARSHIP PROGRAMS

"Sec. 761. (a) To be eligible to receive a grant under this subpart, a State shall establish or have established a State service scholarship program (hereinafter referred to in this subpart as 'State program') and such State shall submit or have submitted assurances that such program complies with the requirements of this section.

"(b) No grant may be made under this subpart unless the State provides assurances that funds received under the grant will be used to fund contractual agreements between the State and individuals who are students in schools of medicine, osteopathy, dentistry, nursing, veterinary medicine, optometry, pharmacy, podiatry, public health, and allied health, graduate programs in health administration, and programs for the training of physicians assistants, expanded function dental auxiliaries, and nurse practitioners. Such agreements shall at a minimum provide—

"(1) adequate notice to the individual of the rights and liabilities of such individual under such agreement;

"(2) that the individual must—

"(A) maintain enrollment in a course of study described in this section until the individual completes the course of study;

"(B) maintain an acceptable level of academic standing (as determined by the educational institution offering such course of study); and

"(C) agree to serve for a period of time equal to one year in a health manpower shortage area for each school year for which the individual was provided a scholarship under the State program, such health manpower shortage area (as designated pursuant to section 332) to be selected by the State, or as otherwise provided in this subpart.

"(3) for payment by or on behalf of the State of all or part of the educational expenses of the individual, but not to exceed tuition, reasonable educational expenses, and a monthly stipend of the same amount and adjusted in the same manner as the amount provided under section 768(g) of this Act;

"(4) that the State shall assign the individual to provide service in a health manpower shortage area, and shall assure such individual, either by direct employment or salary guarantee, a salary, during such period of obligated service, not less than the comparable salary of entry-level individuals employed by the State who possess a similar educational background;

"(5) that the individual may enter a private clinical practice in a health manpower shortage area in lieu of providing services pursuant to an assignment by the State upon application of such individual, but such practice must be subject to terms and conditions no less stringent than terms and conditions provided under section 767; and

"(6) that the State shall be required to enforce the agreement on the same basis as provided in section 768.

No State or school may require a student to accept such a contractual agreement as a condition of admission into a school or program.

"(c) States shall be required to give priority in the award of scholarships to individuals who have previously received a National Health Service Corps scholarship under section 751 (as it existed prior to October 1, 1980).

"(d) Upon the joint request of a State and an individual who has received a scholarship under this subpart and a scholarship as described in subsection (c), the Secretary shall transfer to such State the rights of the United States under the National Health Service Corps Service contract with such individual.

"(e) Any State that has a total of three or more schools of medicine, osteopathy, or dentistry, shall not allocate more than 50 percent of available service scholarships under this subpart to students at any one health professions school.

"ALLOCATION OF FUNDS

"Sec. 762. (a) The Secretary shall make grants to the States as follows:

"(1) Basic grants for which—

"(A) no less than 65 percent of the funds appropriated to carry out this subpart shall be used; and

"(B) the State is not required to provide matching funds as a condition of such grants.

"(2) Matching grants for which—

"(A) the State shall have received basic grants under this subpart;

"(B) the State shall commit one dollar for service scholarships under the State program for every three dollars made available through a matching grant to such State.

"(b) Funds shall be allocated to the States in accordance with the formula:

$$A=B(1/C+D/E)+F(1/G+D/H)$$

in which 'A' is the amount a State shall be allocated; 'B' is the total of funds available for basic grants; 'C' is the number of States participating in the basic grant program; 'D' is the population of a participating State; 'E' is the population of all States participating in the basic grant program; 'F' is the total of funds available for matching grants; 'G' is the number of States participating in the matching grant program; and 'H' is the population of all States participating in the matching grant program."

CONSTRUCTION

Sec. 107. Title VII is amended by inserting the following after section 771:

"Part E—Grants, Loan Guarantees, and Interest Subsidies for Conversion, Renovation, and Construction of Teaching and Research Facilities for Medical, Dental, and Other Health Personnel

"GRANT AUTHORITY; AUTHORIZATION OF APPROPRIATIONS

"Sec. 775. (a) The Secretary may make grants to a school to assist in—

"(1) the renovation, modernization, or conversion of existing facilities for use in the training and research activities of allopathic physicians, osteopathic physicians, dentists, veterinarians, optometrists, podiatrists, pharmacists, and professional public health personnel;

"(2) the conversion of existing facilities for use as ambulatory, primary care teaching facilities for the training of allopathic physicians, osteopathic physicians, and dentists; and

"(3) the construction of facilities for use in the training and research activities of allopathic physicians, osteopathic physicians, dentists, veterinarians, optometrists, podiatrists, pharmacists and professional public health personnel if, in the fiscal year ending September 30, 1978 or thereafter, such school received or was eligible to receive start-up assistance grants under either section 788(g) (as it existed prior to October 1, 1980) or under section 713(a) (as it existed on October 1, 1980).

"(b) For grants under this section there is authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1981 and for each of the succeeding three fiscal years.

"APPROVAL OF APPLICATIONS

"Sec. 776. (a) To be eligible to apply for a grant under section 775(a), the applicant shall be a private school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, or public health, or any group of such schools.

"(b)(1) An application for a grant under section 775(a) or loan guarantee or interest subsidy under section 780, which would involve the construction, conversion, renovation, or modernization of all or part of a hospital or outpatient facility which is affiliated with but not owned by a school eligible for such grant under section 775(a) or loan guarantee or interest subsidy under section 780, shall be submitted jointly by the eligible school and the affiliated hospital or outpatient facility.

"(2) In the case of a joint application submitted under paragraph (1), assistance under section 775(a) or a loan guarantee or interest subsidy under section 780, shall be provided only for that portion of the proposed construction, conversion, renovation, or modernization which the Secretary determines to be reasonably attributable to the needs of such school for teaching or research purposes.

"(c) A grant under section 775 (a) or loan guarantee or interest subsidy under section 780, may be made only if the Secretary determines that the application contains or is supported by reasonable and adequate assurances that—

"(1) there is a need for the construction, conversion, renovation, or modernization and the facility or facilities will be used for the purposes for which the application has been submitted;

"(2) sufficient funds will be available to meet the non-Federal share of the cost of the proposed construction, conversion, renovation, or modernization;

"(3) sufficient funds will be available for effective use of the facility or facilities for the training or research for which the application has been submitted;

"(4) the plans and specifications are in accordance with regulations relating to minimum standards of construction and equipment;

"(5) in accordance with and to the extent required by the provisions of title XV of this Act, an opportunity has been provided to State and local health planning agencies to comment on the proposed construction, conversion, renovation, or modernization; and

"(6) any laborer or mechanic employed by a contractor or subcontractors in the performance of work on the proposed construction, conversion, renovation, or modernization will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (46 Stat. 1494; 40 U.S.C. 276a-276a-5), commonly referred to as the Davis-Bacon Act, and the Secretary of Labor shall have, with respect to such labor standards, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (5 U.S.C. Appendix) and section 2 of the Act entitled 'An Act to effectuate the purpose of certain statutes concerning rates of pay for labor, by making it unlawful to prevent anyone from receiving the compensation contracted for thereunder, and for other purposes', approved June 13, 1934 (4 Stat. 1267; 40 U.S.C. 276c).

"AMOUNT OF GRANT; PAYMENTS

"Sec. 777. (a) The amount of any grant under section 775 (a) shall not exceed 70 percent of the necessary costs of such project. In determining the necessary cost of such project, the Secretary shall exclude from such costs an amount equal to the sum of—

"(1) the amount of any other Federal grant that the applicant has obtained, or is assured of obtaining, which grant will pay for any of such necessary costs; and

"(2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

"(b) Upon approval of any application for a grant under section 775 (a), the Secretary shall reserve, from any appropriation available therefor, the amount of such grant as provided in subsection (a). The Secretary's reservation of any amount under this section may be amended by the Secretary upon his approval of an amendment of the application.

"RECAPTURE OF PAYMENTS

"Sec. 778. If, within twenty years (or in the case of interim facilities, within ten years) after completion of any construction, conversion, renovation or modernization for which a grant under section 775 (a) has been made—

"(1) the school or other owner of the facility or facilities cease to be a public or nonprofit private school or entity;

"(2) the facility or facilities cease to be used for the teaching or research purposes upon which the grant under section 775 (a) was conditioned, (unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from such obligation); or

"(3) the facility or facilities are used for sectarian instruction or as a place for religious worship;

the United States shall be entitled to recover from the applicant or other owner of the facilities the amount bearing the same ratio to the value of the facilities at the time that any events described in this section occurred (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility or facilities are situated) as the amount the grant under section 775(a) bore to the value of such facility or facilities at the time the construction, conversion, renovation, or modernization was completed.

"PRIOR CONSTRUCTION GRANTS

"Sec. 779. The Secretary shall unilaterally release all recipients of grants under section 720(a) (as it existed prior to October 1, 1980) from their contractual obligation to fulfill enrollment increases required by section 721 (as it existed prior to October 1, 1980).

"LOAN GUARANTEES AND INTEREST SUBSIDIES

"Sec. 780. (a)(1) The Secretary may guarantee payment of principal and interest on a loan made to a private school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health by any non-Federal lender or by the Federal Financing Bank for the construction, conversion, modernization, or renovation of facilities as described in section 775(a) (regardless of whether a grant has been made under such section). No loan guarantee under this paragraph may be made after September 30, 1984.

"(2) No school shall qualify for a loan guarantee under paragraph (1) unless such school complies with all the applicable requirements under section 776. The Secretary shall notify both the school receiving the loan and the lender making such loan that the loan guarantee shall be deemed null and void at any time—

"(A) the school receiving the loan ceases to be a nonprofit private school;

"(B) if the facility or portion of the facility for which the loan guarantee was made ceases to be used for the teaching or research purposes upon which the loan guarantee was conditioned, or

"(C) if the facility or portion of the facility is used for sectarian instruction or as a place for religious worship.

"(3) The Secretary may make commitments, on behalf of the United States, to make such loan guarantees prior to the making of such loans. No such loan guarantee may apply to any amount which, when added to any grant under this part or any other law of the United States, exceeds 90 percent of the necessary costs of the construction, conversion, renovation, or modernization for which the loan guarantee is made.

"(b)(1) The United States shall be entitled to recover from the recipient of a loan guarantee under this section the amount of any payments made by the United States pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery. Upon making such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) Any loan guarantee made by the Secretary pursuant to this section shall be incontestable in the hands of a school on whose behalf such guarantee is made, or any person who makes a loan or contracts to make a loan to such school in reliance thereon, except for fraud or misrepresentation on the part of such school or other person.

"(3) To the extent permitted by paragraph (2), any terms and conditions applicable to a loan guarantee under this section may be modified by the Secretary upon a determination that such modification is consistent with the financial interests of the United States.

"(c)(1) The Secretary may pay to the holder of a loan made by a non-Federal lender or by the Federal Financing Bank to a private school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, in order to carry out the construction, conversion, modernization, or renovation of facilities as described in section 775(a) (regardless of whether a grant has been made under such section) such amounts as are sufficient to reduce the net effective interest rate otherwise payable on such loan by not more than 3 percent per annum on loans made prior to October 1, 1980, and not more than 6 percent per annum on loans made on or after October 1, 1980. Such interest subsidy shall be made for and on behalf of the nonprofit private school that received such loan.

"(2) No school shall qualify for an interest subsidy under paragraph (1) unless such school—

"(A) complies with all the applicable requirements under section 776, and

"(B) agrees to repay such interest subsidy plus six percent per annum simple interest if, within 20 years after completion of the construction, conversion, renovation, or modernization for which the interest subsidy was made—

"(i) the school ceases to be a nonprofit private entity;

"(ii) the facility or facilities cease to be used for the teaching or research purpose upon which the interest subsidy was conditioned (unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the school from such obligation); or

"(iii) the facility or facilities are used for sectarian instruction or as a place for religious worship.

"(d) The Secretary may not approve an application for a loan guarantee or interest subsidy payment unless he determines that the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable. Such approval shall include a determination that the rate of interest does not exceed such percent per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States. The Secretary may not approve an application for a loan guarantee, unless he determines that the loan would not be available on reasonable terms and conditions without a guarantee by the United States under this section.

"(e)(1) There is established in the Department of the Treasury a loan guarantee and interest subsidy fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts. Such fund shall be available to the Secretary—

"(A) to discharge responsibilities relating to guarantees issued under this section; and

"(B) for interest subsidy payments as provided by this section.

"(2)(A) There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund, except that the amount appropriated for interest subsidy payments may not exceed $8,000,000 in the fiscal year ending September 30, 1981, $9,000,000 in the fiscal year ending September 30, 1982, $10,000,000 in the fiscal year ending September 30, 1983, and $11,000,000 in the fiscal year ending September 30, 1984.

"(B) There shall also be deposited in the fund moneys, property, and assets received by the Secretary under this section, including any money derived from the sale of assets.

"(C) If at any time the sums in the fund are sufficient to enable the Secretary to discharge commitments regarding loan guarantees and interest subsidy payments pursuant to this section, the Secretary may issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriation Acts. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued hereunder and for such purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subparagraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

"(f) The total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.".

CONFORMING AMENDMENTS

Sec. 108. (a)(1) Section 722(a)(1) (as redesignated by this Act) is amended by striking out "made upon such form, containing such information, and supported by such evidence as the Secretary may require, and otherwise in conformity with this section," in subsection (a)(1).

(2) Section 722(a)(2) is amended—

(A) by striking out ", except that the";

(B) by striking out ", in accordance with regulations,";

(C) by striking out ", in that event";

(D) by striking out "section 731(a)(1). Such insurance shall cease to be effective upon 60 days default by the lender in the payment of any installment of the premiums payable pursuant to subsection (c).";

(E) by inserting "The" after "issuance of the certificate"; and

(F) by inserting "section 717(a)" after "a student described in".

(3) Section 722(a)(3) is amended to read as follows:

"(3) An application submitted pursuant to subsection (a)(1) shall contain an agreement by the applicant that if the loan is covered by insurance the applicant will submit such supplementary reports and statements during the effective period of the loan agreement as may be needed."

(4) Section 722(b) is amended—

(A) by striking out ", in accordance with regulations consistent with section 728," in paragraph (1); and

(B) by striking out "Such regulations may provide for conditioning such insurance, with respect to any loan, upon compliance by the lender with such requirements (to be stated or incorporated by reference in the certificate) as in the Secretary's judgment will best achieve the purpose of this subsection while protecting the financial interests of the United States and promoting the objectives of this subpart, including (but not limited to) provisions as to the reporting of such loans and information relevant thereto to the Secretary and as to the payment of initial and other premiums and the effect of default therein, and including provision for confirmation by the Secretary from time to time (through endorsement of the certificate) of the coverage of specific new loans by such certificate, which confirmation shall be incontestable by the Secretary in the absence of fraud or misrepresentation of fact or patent error" in paragraph (1); and

(C) by striking out "section 726" in paragraph (2) and inserting in lieu thereof "section 715".

(5) Section 722 is amended—

(A) by striking out subsection (c) and redesignating subsections (d) and (e) as subsections (c) and (d), respectively; and

(B) by striking out ", subject to regulation by the Secretary," in subsection (c) (as redesignated by this Act).

(6) Section 723(d) (as redesignated by this Act) is amended—

(A) by striking out "section 732(a)(3), or to pay the required Federal loan insurance premiums";

(B) by inserting "or" before "to make the reports"; and

(C) by inserting "section 722(a)(3)" after "statements required under".

(7) Section 726 is amended—

(A) by striking out "section 733(d)" and inserting in lieu thereof "section 722(e)" in subsection (e);

(B) by inserting ", including interest" after "balance of such loans" in subsection (f); and

(C) by striking out subsection (g) and inserting in lieu thereof the following:

"(g) A debt which is a loan insured under the authority of this subpart may not be released by a discharge in bankruptcy under title 11 of the United States Code unless such discharge is granted—

"(1) after the expiration of the five-year period beginning on the first date, as specified in section 717(b)(2), when repayment of such loan is required;

"(2) upon a finding by the Bankruptcy Court that the non-discharge of such debt would be unconscionable; and

"(3) upon the condition that the Secretary shall not have waived his rights to apply subsection (f) to the borrower and the discharged debt.".

(8) Section 724 (as redesignated by this Act) is amended—

(A) by striking out paragraph (1) of subsection (a) and redesignating paragraphs (2), (3), (4) and (5) as paragraphs (1), (2), (3), and (4), respectively; and

(B) by striking out subsection (c).

(9) Section 726 (as so redesignated by this Act) is amended —

(A) by striking out paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2) and (3), respectively;

(B) by striking out "The term" in paragraph (1) (as redesignated by this paragraph) and inserting in lieu thereof "The terms 'eligible institution' and ";

(C) by inserting "nursing," after "veterinary medicine," in paragraph (1) (as redesignated by this paragraph); and

(D) by striking out "Commissioner of Education" each time it appears and inserting in lieu thereof "Secretary of Education".

(b) Title XII is amended by striking out "799" each place it appears and inserting in lieu thereof "739".

(c)(1) Title VII is amended by striking out "751", "752", "753", "754", "755", "756", and "757", each place they appear and inserting in lieu thereof '765', '766', '767', '768', '769', '770', and '771', respectively.

(2) Section 765 (as redesignated by this Act) is amended—

(A) by striking out "(as defined in section 822)" and inserting in lieu thereof "(as defined in section 839)" in subsection (a);

(B) by striking out subsection (d) and inserting in lieu thereof the following:

"(d)(1) In determining which applications under the Scholarship Program to approve and which contracts to accept, the Secretary shall give priority to applications made and contracts submitted as follows:

"(A) first, to individuals who have previously received one scholarship (but not more than one) under the Scholarship Program;

"(B) second, to individuals who have previously received two or three scholarships under the Scholarship Program;

"(C) third, to individuals who have previously received a scholarship under section 758 (as it existed prior to October 1, 1980);

"(D) fourth, to individuals who are entering the first year of study in a course of study or program described in subsection (b)(1)(B) in such school year.

"(2) Consistent with section 771, and to the extent necessary to carry out such section, the Secretary shall give priority within each category enumerated in paragraph (1) to individuals who will make a commitment to provide health services to Indians through the Indian Health Service.";

(C) by striking out "or under section 758 (relating to scholarships for first-year students of exceptional financial need)" and "(except as provided in section 711)" in subsection (g)(1); and

(D) by striking out subsection (j).

(3) Section 767, (a)(2) (as redesignated by this Act) is amended by striking out "and to provide the individual with income of not less than the income of members of the Corps".

(4) Section 768 (as redesignated by this Act) is amended—

(A) by striking out subsection (a) and redesignating subsections (b), (c), and (d) as subsections (a), (b), and (c), respectively;

(B) by striking out "or" at the end of subsection (a)(2) (as redesignated by this subsection), inserting "or" at the end of subsection (a)(3), and inserting the following after subsection (a)(3):

"(4) fails to accept payment, or instructs the educational instruction in which he is enrolled not to accept payment, in whole or in part, of a scholarship under such contract,";

(C) by striking out "(for any reason)" in subsection (b) and inserting in lieu thereof "(for any reason not specified in subsection (a))".

(5) Section 770 (a) (as redesignated by this Act) is amended—

(A) by striking out the first sentence and inserting in lieu thereof: "There are authorized to be appropriated for scholarships under this subpart $55,000,000 for the fiscal year ending September 30, 1981, $35,000,000 for the fiscal year ending September 30, 1982, $30,000,000 for the fiscal year ending September 30, 1983, and $30,000,000 for the fiscal year ending September 30, 1984", and

(B) by striking out "1981" and "1980" in the second sentence and inserting in lieu thereof "1985" and "1984", respectively.

(6) Section 771(a) (as redesignated by this Act) is amended by striking out "In addition to the sums authorized to be appropriated under section 756(a) to carry out the Scholarship Program, there are authorized to be appropriated $5,460,000 for the fiscal year ending September 30, 1978, $6,300,000 for the fiscal year ending September 30, 1979, $7,200,000 for the fiscal year ending September 30, 1980, and for each of the succeeding four fiscal years such sums as may be specifically authorized by an Act enacted after the date of enactment of this section, to" and inserting in lieu thereof "The Secretary, to the extent needed, shall".

(d)(1) Section 331 is amended—

(A) by striking out subsection (g);

(B) by redesignating subsection (h) as subsection (g);

(C) by striking out "section 751" in subsection (g)(2) and inserting in lieu thereof "section 765".

(2) Section 337 is amended by striking out subsection (c) and inserting in lieu thereof the following:

"(c) Notwithstanding section 14 of the Federal Advisory Committee Act, the Council shall remain in existence until otherwise provided by law.".

(3) Section 338 is amended by striking out subsection (a) and inserting in lieu thereof the following:

"(a) To carry out the purposes of this subpart there are authorized to be appropriated $110,000,000 for the fiscal year ending September 30, 1981, and $130,000,000."

EFFECTIVE DATE

Sec. 109. The amendments made by this title shall become effective on October 1, 1980.

TITLE II—NURSE TRAINING

SHORT TITLE

Sec. 201. This title may be cited as the "Nurse Training Act of 1980".

NURSE TRAINING

Sec. 202. Title VIII is amended to read as follows:

"TITLE VIII—NURSE TRAINING

"PART A—GENERAL PROVISIONS; FINANCIAL DISTRESS AND START-UP GRANTS

"DEFINITIONS

"Sec. 801. (a) For purposes of this title—

"(1) The term 'nonprofit' means the status of an entity owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(2) The term 'school of nursing' means an accredited public or nonprofit private school or program in a State that provides training, leading to a baccalaureate degree, associate degree or diploma in nursing.

"(3) The term 'collegiate school of nursing' means a department, division or other administrative unit in a college or university that provides primarily or exclusively a program of education in professional nursing and allied subjects leading to the degree of bachelor of arts, bachelor of science, bachelor of nursing, or to an equivalent degree, or to a graduate degree in nursing, and included advanced training.

"(4) The term 'associate degree school of nursing' means a department, division, or other administrative unit in a junior college, community college, college, or university that provides primarily or exclusively a two-year program of education in professional nursing and allied subjects leading to an associate degree in nursing or to an equivalent degree.

"(5) The term 'diploma school of nursing' means a school affiliated with a hospital or university, or an independent school, that provides primarily or exclusively a program of education in professional nursing and allied subjects leading to a diploma or to equivalent indicia that such program has been satisfactorily completed.

"(6) The term 'accredited' when applied to a school or program of nurse education means a school or program that is accredited by a recognized body or bodies approved for such purpose by the Secretary of Education, except that a new school or program that, by reason of an insufficient period of operation, is not, at the time of application for a grant or contract under this title, eligible for accreditation by such a recognized body or bodies, shall be deemed accredited for purposes of this title if the Secretary of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of the first entering class in such school.

"(7) The term 'teaching facilities' means facilities used by students, faculty, or administrative personnel for clinical purposes, research activities, libraries, classrooms, offices, auditoriums, dining areas, student activities, or other related purposes necessary for, and appropriate to, the conduct of comprehensive programs of education. Such term includes interim facilities designed to provide teaching space on a short-term (less than ten years) basis while facilities of a more permanent nature are being planned and constructed, but does not include off-site improvement or living quarters.

"(8) The term 'Secretary' means the Secretary of the Department of Health and Human Services.

"(9) The term 'Department' means the Department of Health and Human Services.

"(10) The term 'Council' means the National Advisory Council on Nurse Training, as provided in section 801 of this Act.

"(11) The term 'State' includes, in addition to the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

"(b) Whenever in this title an applicant is required to provide assurances to the Secretary, or an application is required to contain assurances or be supported by assurances, the Secretary shall determine before approving the application that the assurances provided are made in good faith.

"NATIONAL ADVISORY COUNCIL ON NURSE TRAINING

"Sec. 801. (a) There is established in the Public Health Service a National Advisory Council on Nurse Training (hereinafter in this title referred to as the 'Council'), consisting of the Secretary (or his delegate) who shall be Chairman of the Council, and nineteen members appointed by the Secretary (without regard to the provisions of title 5 of the United States Code relating to appointments in the competitive service) from among persons who because of their education, experience, or training are particularly qualified to advise the Secretary with respect to the programs of assistance authorized by this title. The members of the Council shall be appointed as follows:

"(1) twelve shall be representatives of the various fields of nursing, higher and secondary education, and hospitals and other institutions and organizations that provide nursing services;

"(2) three shall be full-time students enrolled in schools of nursing; and

"(3) four shall be members of the general public.

"(b) The Council shall advise the Secretary in the preparation of general regulations and with respect to policy matters arising in the administration of this title.

"(c) The Secretary may use the services of any member or members of the Council in connection with matters related to the administration of this title, for such periods, in addition to conference periods, as he may determine.

"(d) Notwithstanding section 14 of the Federal Advisory Committee Act, the Council shall remain in existence until otherwise provided by law.

"ADVANCE FUNDING

"Sec. 802. An appropriation under an authorization of appropriations for grants or contracts under this title for any fiscal year may be made at any time before such fiscal year and may be included in an Act making an appropriation under such authorization for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation for such grants or contracts before the fiscal year for which such appropriation is authorized.

"DISCRIMINATION ON THE BASIS OF SEX AND RACE PROHIBITED

"Sec. 803. The Secretary may not enter into a contract with or make a grant, loan guarantee, or interest subsidy payment under this title to, or for the benefit of, any school of nursing or other entity that is eligible to receive assistance under programs authorized by this title unless the contract or the application for the grant, loan guarantee, or interest subsidy payment contains assurances that the school or other eligible entity will not discriminate on the basis of sex or race in the admission of individuals to its programs.

"RECORDS AND AUDITS

"Sec. 804. (a) Each entity that receives a grant, loan, loan guarantee, or interest subsidy or that enters into a contract under this title, shall establish and maintain such records as the Secretary shall by regulation or order require.

"(b) Each entity that received a grant or entered into a contract under this title shall provide for a biennial financial audit of any books, accounts, financial records, files, and other papers and property that relate to the disposition or use of the funds received under such grant or contract. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with the standards and requirements of the individual or agency that conducts the audit and any standards applicable to the performance of the audit, as the Secretary may by regulation provide.

"(c) A student recipient of a traineeship or loan under this title shall not be required to comply with subsection (a) or (b).

"(d) Each entity that is required to establish and maintain records or to provide for an audit under this section shall make such books, documents, papers, and records available to the Secreatry or the Comptroller General of the United States, or their duty authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable request therefor.

"CONTRACTS

"Sec. 805. Contracts authorized by this title may be entered into without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529, 41 U.S.C. 5).

"APPLICATIONS AND PAYMENT

"Sec. 806. (a) No grant may be made or contract entered into under this title unless an application therefor has been submitted to and approved by the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(b) Grants made under this title may be paid—

"(1) in advance or by way of reimbursement;

"(2) at such intervals and on such conditions as the Secretary may find necessary; and

"(3) with appropriate adjustments on account of overpayments or underpayments previously made.

"DIFFERENTIAL TUITION AND FEES

"Sec. 807. The Secretary may not enter into a contract with, or make a grant, loan guarantee, or interest subsidy payment under this title to or for the benefit of, any school of nursing or other entity if the tuition levels or educational fees at such school, program, or training center are higher for certain students solely on the basis that such students are the recipients of traineeship, loans, loan guarantees, service scholarships, or interest subsidies from the Federal Government.

"HEALTH PERSONNEL DATA

"Sec. 808. (a) The Secretary shall establish within the National Center for Health Statistics and the Bureau of Health Manpower jointly, a program, including a uniform nursing data reporting system, to collect, compile, and analyze data on nurses and nurse training. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional), place or places of practice, professional specialty, practice characteristics, age, sex, and socioeconomic background of nursing personnel and other demographic information regarding nurses. Such data shall also include—

"(1) the number and distribution of nurses, by type of employment and location of practice;

"(2) the number of nurses who are practicing full time and who are employed part-time, within the United States and within each State;

"(3) the average rate of compensation for nurses, by type of practice and location of practice;

"(4) the number of nurses with advance training or graduate degrees in nursing by specialty, including nurse practitioners, nure clinicians, nurse researchers, nurse educators, and nurse supervisors and administrators; and

"(5) the number of registered nurses entering the United States annually from other nations, by country of nurse training and by immigrant status.

"(b) In carrying out subsection (a), the Secretary shall collect available information from appropriate local, State, and Federal agencies and other appropriate sources, and may enter into contracts, when necessary, to obtain such information, subject to the provisions of section 809.

"(c) The Secretary shall conduct, or enter into contracts for the conduct of, analytic and descriptive studies of nurses, including—

"(1) the supply (both current and projected, within the United States and within each State) of registered nurses, licensed, practical and vocational nurses, nurse's aides, registered nurses with advanced training or graduate degrees, and nurse practitioners;

"(2) the distribution, within the United States and within each State, of such nurses so as to determine (A) areas of the United States that have an oversupply or undersupply of nurses, or that have an adequate supply of such nurses in relation to the population of the area, and (B) the demand for the services provided by such nurses; and

"(3) the current and future requirements for such nurses, nationally and within each State.

"(d) Any school of nursing or other entity receiving funds under this title shall submit a report to the Secretary on an annual basis, containing such information as is necessary to assist the Secretary in carrying out this section. The Secretary shall not require the collecting or transmittal of any information under this subsection which is not readily available to such school or entity. Information under this subsection shall be collected or transmitted only to the extent permitted by section 809.

"(e) The Secretary shall submit, on a biennial basis, a report to the President and Congress on the status of nursing personnel in the United States. Such report shall include a description and analysis of the information collected pursuant to this section.

"(f) There are authorized to be appropriated to carry out the purposes of this section $1,000,000 in the fiscal year ending September 30, 1981, $1,250,000 in the fiscal year ending September 30, 1982, and $1,500,000 in each of the succeeding two fiscal years.

"PERSONAL DATA

"Sec. 809. (a) The Secretary and any entity receiving funds under title VIII, in securing and maintaining any record of individually identifiable personal data (hereinafter in this subsection referred to as 'personal data') for the purposes of carrying out section 808 or any grant or contract under this title, shall—

"(1) inform each individual who is asked to supply personal data whether such individual is legally required to supply such data and the specific consequences of providing or not providing such data; and

"(2) upon request of an individual, inform such individual—

"(A) as to whether such individual is the subject of personal data secured or maintained by the Secretary or entity pursuant to this title, and make such data available to such individual in a form comprehensible to him, and

"(B) concerning the use of personal data respecting such individual, the identity of the persons who will use such data, and the relationship of such persons to the grant or contract requiring such personal data under this title.

"(b)(1) Personal data collected by the Secretary, entity, or local, State, or Federal agency pursuant to this title may not be made available or disclosed by the Secretary, entity, or local, State, or Federal agency to any person other than the individual who is the subject of such data, unless—

"(A) such person to whom such personal data was made available or disclosed requires such data in order to carry out the purposes of this title;

"(B) such personal data is made available or disclosed in response to a demand for such data made by means of compulsory legal process; or

"(C) the informed written consent of the individual who is the subject of such data has been obtained.

"(2) Data collected by the Secretary pursuant to this title that is not personal data shall be made available to bona fide researchers and policy analysts (including the Congress) for the purposes of assisting in the conduct of studies respecting health personnel.

"NONINTERFERENCE WITH ADMINISTRATION OF INSTITUTIONS

"Sec. 810. Nothing contained in this title shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any direction, or supervision of, or control over, or impose any requirement or condition with respect to, the personnel, curriculum, methods of instruction, or administration of any institution.

"FINANCIAL DISTRESS GRANTS

"Sec. 811. (a) The Secretary may make grants to, and enter into contracts with, a school of nursing that is in serious financial distress for the purposes of assisting such school to—

"(1) meet the costs of operation;

"(2) meet applicable accreditation requirements if such school has a special need to be assisted in meeting such requirements; or

"(3) carry out appropriate operational, managerial, and financial reforms.

"(b) Any grant or contracts under this section may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree to—

"(1) disclose any financial information or data necessary to determine the sources or causes of such school's financial distress;

"(2) conduct a comprehensive cost analysis study in cooperation with the Secretary; and

"(3) carry out appropriate operational, managerial, and financial reforms including the securing of increased financial support from State or local governmental units or the increasing of tuition.

"(c) In the case of a school that has received a grant or contract under this section in any fiscal year, the amount granted to such school under this section in any subsequent fiscal year may not exceed 75 percent of the amount granted to such school under this section in any fiscal year preceding such subsequent fiscal year. No school may receive a grant under this section if such school has previously received support for three or more years under this section or under section 815 (as it existed prior to October 1, 1980).

"(d) For the purpose of making grants and entering into contracts to carry out this section, there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1981, and in each of the succeeding three fiscal years.

"ADVANCED FINANCIAL DISTRESS GRANTS

"Sec. 812. (a) The Secretary may make grants to, and enter into contracts with, a school of nursing for the purposes of meeting the costs of operation and of appropriate operational, managerial, and financial reforms if such school is in serious financial distress and has previously received grant support under section 811 or under section 815 (as it existed prior to October 1, 1980).

"(b) No school may receive a grant or contract under this section unless—

"(1) the school has submitted to the Secretary a plan providing for the institution to achieve financial solvency within five years and has agreed to carry out such plan;

"(2) such plan has been reviewed by a panel selected by the Secretary and consisting of three experts in the field of financial management who are not directly affiliated to the school or the Federal Government; and

"(3) the Secretary determines, after consultation with such panel, that such plan has a reasonable likelihood of achieving success.

"(c) The panel described in subsection (b)(2) shall be appointed by the Secretary within 30 days after the date of receipt of the school's plan and shall be dissolved no later than 45 days after the panel's recommendation has been transmitted to the Secretary. Members of the panel, while serving on the business of the panel, shall be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which they perform duties.

"(d) No school may receive a grant or contract under this section unless in the same year as such grant or contract, the school shall have received, or have a legally binding commitment to receive, a grant or contract from a State or local government or combination thereof for the exclusive purpose of alleviating such school's financial distress. Such grant or contract from a State or local government or combination thereof shall, in the first year of any support under this section, exceed any grant made in the preceding year by such State or local government by an amount equal to or greater than the amount of the proposed grant or contract under this section. In subsequent years of support under this section, such grant or contract from a State or local government or combination thereof shall exceed any grant made by such State or local government or combination thereof in the year prior to the first year of support under this section by an amount equal to or greater than the amount of the grant or contract under this section for such years.

"(e) No school may receive support under this section for more than five years. No grant or contract for support under this section shall be in an amount greater than (1) 75 percent in the third year, (2) 50 percent in the fourth year, and (3) 25 percent in the fifth year, of the average annual amount received in the first two years of grant or contract support under this section.

"(f) An application for a grant or contract under this section must contain or be supported by assurances that the applicant will, in carrying out its function as a school of nursing, expend during the fiscal year for which such grant is sought an amount of funds from non-Federal sources (other than funds for construction and the grant or contract referred to in subsection (d)) at least as great as the average annual amount of funds from non-Federal sources expended by such applicant in the preceding two years.

"(g) For the purpose of making grants and entering into contracts to carry out this section, there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1981 and in each of the succeeding three fiscal years.

"START-UP ASSISTANCE

"Sec. 813. (a) For the purposes of meeting national and regional needs for nurses, the Secretary may make a grant to a new school of nursing which begins instruction after July 1, 1980. No school may receive a grant under this section unless the number of full-time students enrolled in its first school year of operation will exceed twenty-three.

"(b) The amount of any grant under this section may not exceed the following:

"(1) In the year preceding the first year in which such school has students enrolled, an amount equal to the product of $6,000 and the number of full-time students the Secretary estimates will enroll in such school in such first year.

"(2) In the first year in which such school has students enrolled, an amount equal to the product of $5,000 and the number of full-time students enrolled in such school in such year.

"(3) In the second year in which such school has students enrolled, an amount equal to the product of $2,500 and the number of full-time students enrolled in such school in such year.

Estimates of the number of full-time students enrolled in a school may be made on the basis of assurances provided by the school.

"(c) The Secretary shall give priority in the award of grants under this section to applicants for whom the receipt of such grant would facilitate the acceleration of the date upon which instruction would begin or increase the number of students to be enrolled in the entering class. The Secretary shall also give priority to applicants who will, by virtue of an affiliation with one or more existing health professions institutions, be able to make use of existing facilities and resources.

"(d) The Secretary shall give special consideration to any application submitted by a school for a grant under this section if such school will be located in a health manpower shortage area (designated under section 332).

"(e) For purposes of this section, any school of nursing shall be considered a new school for any year if such year is—

"(1) the year preceding the first year in which such school has students enrolled;

"(2) the first year such school has students enrolled; and

"(3) the year following the first year such school has students enrolled.

"(f) For the purpose of making grants to carry out this section, there are authorized to be appropriated $1,000,000 in the fiscal year ending September 30, 1980, and in each of the succeeding three fiscal years.

"PART B—STUDENT LOANS

"LOAN AGREEMENTS

"Sec. 820. (a) The Secretary is authorized to enter into agreements with any school of nursing for the continuation of student loan funds which were established under section 835 (as it existed prior to October 1, 1980) or the predecessors of such section.

"(b) Each agreement entered into under this section shall—

"(1) provide for the continuation by the school of the previously established student loan fund;

"(2) provide for deposit in the fund of principal and interest on loans made from the fund, and any other earnings of the fund;

"(3) provide that the fund shall be used for—

"(A) loans to students of the school in accordance with the agreement; and

"(B) costs of collection of such loans and interest thereon;

"(4) provide that loans may be made from such fund only to students pursuing a full-time or half-time course of study at the school leading to a baccalaureate or associate degree in nursing or an equivalent degree, or a diploma in nursing, or a graduate degree in nursing; and

"(5) contain such other provisions as are necessary to protect the financial interests of the United States.

"LOAN PROVISIONS

"SEC. 821. (a) The total of the loans to any one student for any academic year (or its equivalent) made by schools of nursing from loan funds continued pursuant to agreements under this part may not exceed $2,500. No one student may receive loans from such fund totaling more than $10,000.

"(b) Loans from any such student loan fund shall be made on such terms and conditions as the school making such loans may determine, except that—

"(1) such a loan may be made only to a student who is in need of the amount of the loan to pursue a full-time or half-time course of study at the school leading to a baccalaureate or associate degree in nursing or an equivalent degree, a diploma in nursing, or a graduate degree in nursing;

"(2) such loan shall be repayable in equal or graduated periodic installments (with the right of the borrower to accelerate repayment) over the ten-year period beginning nine months after the student ceases to pursue a full-time or half-time course of study at a school of nursing, excluding from such 10-year period—

"(A) periods (up to three years) of active duty performed by the borrower as a member of a uniformed service or the National Health Service Corps or as a full-time volunteer under the Peace Corps Act or under title I of the Domestic Volunteer Service Act of 1973; and

"(B) periods (up to five years) during which the borrower is pursuing a full-time course of study at a collegiate school of nursing leading to a baccalaureate degree in nursing or an equivalent degree, or to a graduate degree in nursing, or is otherwise pursuing advanced professional training in pursuing (or training to be a nurse anesthetist);

"(3) the liability to repay the unpaid balance of such loan and accrued interest thereon shall be canceled upon the death of the borrower, or if the Secretary determines that such borrower has become permanently and totally disabled;

"(4) such loan, if made on or after October 1, 1980, shall bear interest on the unpaid balance of the loan, computed for the periods during which the loan is repayable, at the rate of 7 percent per annum;

"(5) such loan shall be made without security or endorsement, except that if the borrower is a minor and the note or other evidence of obligation executed by such borrower would not, under the applicable law, create a binding obligation, either security or endorsement may be required;

"(6) no note or other evidence of any such loan may be transferred or assigned by the school making the loan except that, if the borrower transfers to another school participating in the program under this part, such note or other evidence of a loan may be transferred to such other school.

"(c) An agreement entered into by the Secretary with a school pursuant to this part shall include provisions designed to make loans from the student loan fund reasonably available (to the extent of the available funds in such fund) to all eligible students in the school in need thereof.

"(d) A school may provide that, during the repayment period of a loan from a loan fund continued pursuant to an agreement under this subpart, payments of principal and interest by the borrower with respect to all the outstanding loans made to such student from such loan funds shall be at a rate equal to not less than $15 per month.

"(e) The liability to repay the unpaid balance including accrued interest of any loan made before October 1, 1984 from any loan fund established before October 1, 1980 and continued under this part may be canceled upon the same terms and conditions (and subject to the same limitations) as were specified in sections 836(b)(3), 836(h), 836(i), and 836(j) (as such sections were in effect prior to October 1, 1980).

"DISTRIBUTION OF ASSETS FROM LOAN FUNDS

"SEC. 822. (a) After September 30, 1984 and not later than March 31, 1985, each school that established a loan fund under an agreement pursuant to section 835(b) (as it existed prior to October 1, 1980) and continued such loan fund under an agreement pursuant to section 820 (as it existed on October 1, 1980) shall provide for a capital distribution of the balance of the loan fund. The distribution of such loan fund by each school shall be as follows:

"(1) The Secretary shall first be paid an amount bearing the same ratio to such balance in such fund at the close of September 30, 1984, as the total amount of the Federal capital contributions to such fund pursuant to section 835 (b) (2) (A) (as it existed prior to October 1, 1980) bears to the total amount in such fund derived from such Federal capital contributions and from funds deposited therein pursuant to section 835 (b) (2) (B) (as it existed prior to October 1, 1980) and section 839 (b) (2) as it existed on October 1, 1980).

"(2) The remainder of such balance shall be paid to the school.

"(b) After March 31, 1985, each school that made an agreement under this part shall pay to the Secretary, not less often than quarterly, the same proportionate share of amounts received by the school after September 30, 1984, in payment of principal or interest on loans made from the loan fund, as was determined for the Secretary under subsection (a) (1).

"PART C—SPECIAL PROJECTS

"GENERAL PROVISIONS

"SEC. 830. (a) The Secretary may make grants to, and enter into contracts with, schools of nursing and other eligible entities, in order to meet the costs of carrying out special projects as provided in this part.

"(b) (1) In calculating the amount of each special project grant or contract under this part which is made to an eligible school, the Secretary shall add to the Federal share of the cost of carrying out such project an amount equal to 20 percent of such federal share of the cost if the school provides assurances to the Secretary that it has met or will meet two of the following:

"(A) the school's first year student enrollment is the same or greater than the first year student enrollment in the previous school year;

"(B) the school provides, or plans to provide within 12 months, a program of continuing education for practicing nurses;

"(C) the school provides, or plans to provide within 12 months, at least one required course, or some comparable amount of instruction as part of other required courses, in health policy and health care economics; and

"(D) the school's tuition and fees for both in-State and out-of-State students is not more than 10 percent greater than such school's tuition and fees for such students in the previous school year.

"(2) If an application for a grant or contract under this part is submitted jointly by more than one school, and not all such schools submitting such application provide the assurances required under paragraph (1) in order to receive the additional funds under such paragraph, the Secretary may provide such additional funds to such schools providing such assurances, and deny such additional funds to such schools failing to provide such assurances.

"(3) The willingness or failure of any school to provide assurances under paragraph (1) shall not affect whether such school receives a grant or contract under this part.

"(4) Such additional funds shall be used for the purpose of supporting any aspect of the educational programs of such schools, and any school receiving such additional funds shall be required to provide assurances that such funds are being used for such purpose.

"(c) Except in the case of applications for continuation awards, the Secretary shall give special consideration for grants and contracts under this part to applications made by applicants who would not otherwise have received a grant or contract under this part for the same fiscal year.

"ADVANCED NURSE TRAINING PROGRAMS

"SEC. 831. (a) The Secretary may make grants to and enter into contracts with collegiate schools of nursing to meet the costs of projects to—

"(A) plan, develop and operate;

"(B) significantly expand; or

"(C) maintain existing;

programs for the advanced training of professional nurses to teach in the various fields of nurse training, to serve in administrative or supervisory capacities, or to serve in other professional nursing specialties (including service as nurse clinicians) determined by the Secretary to require advanced training.

"(b) The Secretay shall give special consideration under subsection (a) to applications—

"(1) which would provide a program for advanced training in geographic areas lacking such a program; and

"(2) which include a program for advanced training on a part-time basis.

"(c) For payments under grants and contracts under this section there are authorized to be appropriated $20,000,000 for the fiscal year ending September 30, 1981, $22,000,000 for the fiscal year ending September 30, 1982, $24,000,000 for the fiscal year ending September 30, 1983, and $26,000,000 for the fiscal year ending September 30, 1984.

"NURSE PRACTITIONER PROGRAMS

"SEC. 832. (a) (1) The Secretary may make grants to and enter into contracts with schools of nursing, to meet the cost of projects to—

"(A) plan, develop, and operate;

"(B) significantly expand; or

"(C) maintain existing;

programs for the training of nurse practitioners.

"(2) For purposes of this section, the term 'programs for the training of nurse practitioners' means educational program for graduates of collegiate schools of nursing that have as their objective the education of nurses who will, upon completion of their studies in such programs, be qualified to effectively provide primary health care as nurse practitioners.

"(b) The Secretary shall give special consideration to applications for grants or contracts—

"(1) for programs for the training of nurse practitioners who will practice in health manpower shortage areas (designated under section 332); and

"(2) for programs to be located in geographic areas which do not have such a program.

"(c) For payments under grants and contracts under this section there are authorized to be appropriated $20,000,000 for the fiscal year ending September 30, 1981, $22,000,000 for the fiscal year ending September 30, 1982, $24,000,000 for the fiscal year ending September 30, 1983, and $26,000,000 for the fiscal year ending September 30, 1984.

"TRAINEESHIPS FOR ADVANCED TRAINING OF PROFESSIONAL NURSES

"Sec. 833. (a) The Secretary may make grants to schools of nursing to cover the costs of traineeships for the training of professional nurses—

"(1) to teach in the fields of nurse training (including practical nurse training);

"(2) to serve in administrative or supervisory capacities;

"(3) to serve as nurse practitioners; or

"(4) to serve in other professional nursing specialties determined by the Secretary to require advanced training.

"(b) Payments to institutions under this section may be used only for traineeships and shall be limited to such amounts as the Secretary finds necessary to cover the costs of tuition and fees, and stipends and allowances (including travel and subsistence expenses) for such trainees.

"(c) There are authorized to be appropriated for the purposes of this section $20,000,000 for the fiscal year ending September 30, 1981, $22,000,000 for the fiscal year ending September 30, 1982, $24,000,000 for the fiscal year ending September 30, 1983, and $26,000,000 for the fiscal year ending September 30, 1984.

"EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

"Sec. 834. (a)(1) For the purpose of increasing nursing education opportunities for individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary), the Secretary may make grants to and enter into contracts with schools of nursing and other public or private non-profit health or educational entities to assist in meeting the costs described in paragraph (2).

"(2) A grant or contract under paragraph (1) may be used by such school or other entity to meet the costs of—

"(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds for education and training in nursing;

"(B) providing counseling or other services designed to assist such individuals to enter and successfully complete their education at such a school;

"(C) providing, prior to the entry of such individuals into the regular course of education of such school, preliminary education designed to assist such individuals in successfully completing such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education; and

"(D) publicizing existing sources of financial aid available to students in the education program of such a school and to students who are undertaking training necessary to qualify them to enroll in such a program, with particular emphasis on individuals—

"(i) who are in high school; and

"(ii) who are practicing nurses and nursing assistants who want to upgrade their educational credentials.

"(b) Not more than 20 percent of the funds appropriated under this section may be used for grants or contracts to entities that are not schools of nursing. Not more than 5 percent of the funds appropriated under this section may be used for grants or contracts having the primary purpose of informing individuals about the existence and general nature of health careers.

"(c) There are authorized to be appropriated to carry out the provisions of this section $2,000,000 for the fiscal year ending September 30, 1981, $2,500,000 for the fiscal year ending September 30, 1982, and $3,000,000) for each of the two succeeding fiscal years.

"CURRICULUM DEVELOPMENT

"Sec. 835. (a) For the purposes of improving and strengthening the curriculum of schools of nursing, the Secretary may make grants to and enter into contracts with schools of nursing to assist in meeting the costs of projects to plan, develop, and establish courses or expand or strengthen instruction in the following areas:

"(A) health policy and health care economics;

"(B) maternal and child health, including pediatrics;

"(C) geriatrics;

"(D) diet and nutrition; and

"(E) public health and community health education.

"(b) The Secretary may set aside not more than 20 percent of any amounts appropriated to carry out this section to make grants to assist schools to plan, develop, and implement innovative curriculum programs in health areas not specified in subsection (a).

"(c) There are authorized to be appropriated under this section $6,000,000 in the fiscal year ending September 30, 1981, $7,000,000 in the fiscal year ending September 30, 1982, $8,000,000 in the fiscal year ending September 30, 1983, and $9,000,000 in the fiscal year ending September 30, 1984.

"SUPPORT FOR PRACTICING NURSES

"Sec. 836. (a) For the purposes of encouraging schools of nursing to provide support for practicing nurses and nursing aides, the Secretary may make grants to, and enter into contracts with, schools of nursing to assist in meeting the cost of projects to provide—

"(1) continuing education for nurses;

"(2) programs, including continuing education, to provide professional support for nurses, including nurse practitioners practicing in health manpower shortage areas;

"(3) appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire to engage actively in the nursing profession;

"(4) training and education to upgrade the skills of licensed vocational or practical nurses, and nursing assistants and other paraprofessional nursing personnel, especially with regard to providing nursing services to special populations such as geriatric patients in nursing homes; and

"(5) programs to assist graduates of diploma and associate degree schools of nursing to upgrade their educational credentials.

"(b) There are authorized to be appropriated for the purposes of this section $10,000,000 for the fiscal year ending September 30, 1981, $11,000,000 for the fiscal year ending September 30, 1982, $12,000,000 for the fiscal year ending September 30, 1983, and $13,000,000 for the fiscal year ending September 30, 1984.

"IMPROVEMENT OF NURSING EDUCATION

"Sec. 837. (a) For the purposes of assisting in the improvement of nursing education, the Secretary may make grants to and enter into contracts with schools of nursing to assist in meeting the cost of projects to—

"(1) assist in mergers among hospital training programs, or between hospital training programs and academic institutions, or other cooperative arrangements among hospitals and academic institutions, that will result in the improvement of the nursing education provided;

"(2) significantly improve the quality and extent of clinical training provided to students in collegiate schools of nursing;

"(3) plan, develop, establish, or maintain programs of research in nursing education;

"(4) plan, develop, and demonstrate methods of reducing the cost of nursing education without impairing the quality of such education; and

"(5) help to increase the supply or improve the distribution of adequately trained nursing personnel (including nursing personnel who are bilingual) by geographic area or by specialty group.

"(b) There are authorized to be appropriated to carry out the purposes of this section, $12,000,000 in the fiscal year ending September 30, 1981, $13,000,000 in the fiscal year ending September 30, 1982, $14,000,000 in the fiscal year ending September 30, 1983, and $15,000,000 in the fiscal year ending September 30, 1984.

"PART D—GRANTS AND LOAN GUARANTEES AND INTEREST SUBSIDIES FOR RENOVATION AND CONSTRUCTION OF TEACHING FACILITIES FOR NURSES

"GRANT AUTHORITY; AUTHORIZATIONS OF APPROPRIATIONS

"Sec. 840. (a) The Secretary may make grants to a school of nursing to assist in—

"(1) the renovation, modernization, or conversion of existing facilities for use in the training of nurses, and

"(2) the construction of facilities for use in the training of nurses if the first class of students is enrolled in the school in the fiscal year ending September 30, 1978 or thereafter.

"(b) For grants under this section there is authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1981 and for each of the succeeding three fiscal years.

"APPROVAL OF APPLICATIONS

"Sec. 841. A grant under section 840(a) or loan guarantee or interest subsidy under section 845, may be made only if the Secretary determines that the application contains or is supported by reasonable and adequate assurances that—

"(1) there is a need for the construction, conversion, renovation, or modernization and the facility or facilities will be used for the purposes for which the application has been submitted;

"(2) for not less than twenty years (or in the case of interim facilities, within 10 years) after completion of the project, the facility will be used for the purposes for which the grant under section 840(a) was made, and will not be used for sectarian instruction or as a place for religious worship;

"(3) sufficient funds will be available to meet the non-Federal share of the cost of the proposed construction, conversion, renovation, or modernization;

"(4) sufficient funds will be available for effective use of the facility or facilities for the training for which the application has been submitted;

"(5) the plans and specifications are in accordance with regulations relating to minimum standards of construction and equipment;

"(6) in accordance with and to the extent required by the provisions of title XV of this Act, an opportunity has been provided to State and local health planning agencies to comment on the proposed construction, conversion, renovation, or modernization; and

"(7) any laborer or mechanic employed by a contractor or subcontractors in the performance of work on the proposed construction, conversion, renovation, or modernization will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (46 Stat. 1494; 40 U.S.C. 276a—276a-5), commonly referred to as the Davis-Bacon Act, and the Secretary of Labor shall have, with respect to such labor standards, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (5 U.S.C. Appendix) and section 2 of the Act entitled 'An Act to effectuate the purpose of certain statutes concerning rates of pay for labor, by making it unlawful to prevent anyone from receiving the compensation contracted for thereunder, and for other purposes', approved June 13, 1934 (4 Stat. 1267; 40 U.S.C. 276c).

"AMOUNT OF GRANTS; PAYMENTS

"Sec. 842. (a) The amount of any grant under section 840(a) shall not exceed 70 percent of the necessary costs of such project. In determining the necessary cost of such project, the Secretary shall exclude from such costs an amount equal to the sum of—

"(1) the amount of any other Federal grant that the applicant has obtained, or is assured of obtaining, which grant will pay for any of such necessary costs; and

"(2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

"(b) Upon approval of any application for a grant under section 840(a), the Secretary shall reserve, from any appropriation available therefore, the amount of such grant as provided in subsection (a). The Secretary's reservation of any amount under this section may be amended by the Secretary upon his approval of an amendment of the application.

"RECAPTURE OF PAYMENTS

"Sec. 843. If, within twenty years (or in the case of interim facilities, within 10 years) after completion of any construction, conversion, renovation, or modernization for which a grant under section 840(a) has been made—

"(1) the school or other owner of the facility or facilities ceases to be a public or nonprofit private school or entity;

"(2) the facility or facilities cease to be used for the training purposes upon which the grant under section 840(a) was conditioned (unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the school or other owner from such obligation); or

"(3) the facility or facilities are used for sectarian instruction or as a place for religious worship;

the United States shall be entitled to recover from the applicant or other owner of the facility or facilities the amount bearing the same ratio to the value of the facility or facilities at the time that any of the events described in clause (1), (2), or (3) occurred (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility or facilities are situated) as the amount the grant under section 840(a) bore to the value of such facility or facilities at the time the construction, conversion, modernization, or renovation was completed.

"PRIOR CONSTRUCTION GRANTS

"Sec. 844. The Secretary shall unilaterally release all recipients of grants under section 801 (as it existed prior to October 1, 1980) from their contractual obligation to fulfill enrollment increases required by section 802 (as it existed prior to October 1, 1980).

"LOAN GUARANTEES AND INTEREST SUBSIDIES

"Sec. 845. (a)(1) The Secretary may guarantee payment of principal and interest on a loan made to a private school of nursing by any non-Federal lender or by the Federal Financing Bank for the construction, conversion, modernization, or renovation of such facility or facilities as described in section 840(a) (regardless of whether a grant has been made under such section). No loan guarantee under this paragraph may be made after September 30, 1984.

"(2) No school shall qualify for a loan guarantee under paragraph (1) unless such school complies with all of the applicable requirements of section 841. The Secretary shall notify both the school receiving the loan and the lender making such loan that the loan guarantee shall be deemed null and void at any time—

"(A) the school receiving the loan ceases to be a nonprofit private school;

"(B) if the facility or portion of such facility for which the loan guarantee was made ceases to be used for the teaching or research purposes upon which the loan guarantee was conditioned; or

"(C) if such facility or portion of such facility is used for sectarian instruction or as a place for religious worship.

"(3) The Secretary may make commitments, on behalf of the United States, to make such loan guarantees prior to the making of such loans. No such loan guarantee may apply to any amount which, when added to any grant under this part or any other law of the United States, exceeds 90 percent of the necessary costs of the construction, conversion, renovation, or modernization for which the loan guarantee is made.

"(b)(1) The United States shall be entitled to recover from the recipient of a loan guarantee under this section the amount of any payment made by the United States pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery. Upon making such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(2) Any loan guarantee made by the Secretary pursuant to this section shall be incontestable in the hands of a school on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such school in reliance thereon, except for fraud or misrepresentation on the part of such school or such other person.

"(3) To the extent permitted by paragraph (2), any terms and conditions applicable to a loan guarantee under this section may be modified by the Secretary upon a determination that such modification is consistent with the financial interests of the United States.

"(c)(1) The Secretary may pay to the holder of a loan made by a non-Federal lender or by the Federal Financing Bank to a private school of nursing in order to carry out the construction, conversion, modernization, or renovation of facilities as described in section 840(a) (regardless of whether a grant has been made under such section) such amounts as are sufficient to reduce the net effective interest rate otherwise payable on such loan by not more than 3 percent per annum on loans made prior to October 1, 1980, and not more than 6 percent per annum on loans made on or after October 1, 1980. Such interest subsidy shall be made for and on behalf of the nonprofit private school that received such loan.

"(2) No school shall qualify for an interest subsidy under paragraph (1) unless such school—

"(A) complies with all the applicable requirements of section 841; and

"(B) agrees to repay such interest subsidy plus six percent per annum simple interest if, within 20 years after completion of the construction, conversion, renovation, or modernization for which the interest subsidy was made—

"(i) the school ceases to be a nonprofit private school;

"(ii) the facility or facilities cease to be used for the training purpose upon which the interest subsidy was conditioned (unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the school from such obligation); or

"(iii) the facility or facilities are used for sectarian instruction or as a place for religious worship.

"(d) The Secretary may not approve an application for a loan guarantee or interest subsidy payment unless he determines that the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable. Such approval shall include a determination that the rate of interest does not exceed such percent per annum on the principal obligation outstanding as the Secretary determines to be reasonable taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States. The Secretary may not approve an application for a loan guarantee, unless he determines that the loan would not be available on reasonable terms and conditions without a guarantee by the United States under this section.

"(e)(1) There is established in the Department of the Treasury a loan guarantee and interest subsidy fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts. Such fund shall be available to the Secretary—

"(A) to discharge responsibilities relating to guarantees issued under this section; and

"(B) for interest subsidy payments as provided by this section.

"(2)(A) there are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund, except that the amount appropriated for interest subsidy payments may not exceed $2,000,000 in the fiscal year ending September 30, 1981, $2,500,000 in the fiscal year ending September 30, 1982, $3,000,000 in the fiscal year ending September 30, 1983, and $3,500,000 in the fiscal year ending September 30, 1984.

"(B) There shall also be deposited in the fund moneys, property, and assets received by the Secretary under this section, including any money derived from the sale of assets.

"(C) If at any time the sums in the fund are insufficient to enable the Secretary to discharge commitments regarding loan guarantees and interest subsidy payments pursuant to this section, the Secretary may issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury, but only in such amounts as may be specified from time to time in appropriation Acts. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued hereunder and for such purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subparagraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this subsection shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

"(f) The total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.".

EFFECTIVE DATE

SEC. 303. The amendments made by this title shall become effective on October 1, 1980.

HIGHLIGHTS AND ANALYSIS OF MAJOR PROGRAMS CONTAINED IN THE "HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980"

The "Health Professions Educational Assistance and Nurse Training Act of 1980" attempts to comprehensively revise federal programs which assist schools and students in the health professions and nursing. The following analysis compares existing programs with proposed new programs under my bill.

SPECIAL PROJECTS

Existing law provides a number of authorities for special projects grants to be made to health professions and nursing schools. Generally special projects have been a successful means of accomplishing national goals because the purposes of each project are well-delineated and each recipient school has known in a fairly clear manner what was expected of them. My bill continues, with considerable modifications in some cases, the most effective of the special projects from existing law. These projects are ones which provide support for: residency training in general internal medicine, general pediatrics, family medicine, and general dentistry; departments of family medicine; area health education centers; training physicians' assistants and expanded function dental auxiliaries; interdisciplinary training; educational assistance to individuals from disadvantaged backgrounds; special projects and traineeships in public health and health administration; advanced nurse training projects; training for nurse practitioners; traineeships for advanced nurse training (including nurse practitioners); and special projects and traineeships in allied health.

In an effort to expand special projects and increase their impact on the achievement of national health goals, a number of new special projects areas have been added. These new projects will provide support for: remote site training; programs to provide professional support mechanisms for physicians and dentists practicing in medically underserved areas; residency training in preventive medicine and physical medicine and rehabilitation; clinical training in schools of veterinary medicine, optometry, podiatry, and pharmacy; curriculum development in health policy and health care economics; continuing education projects; projects to demonstrate means of reducing the cost of health professions and allied health education; curriculum development in health professions, allied health and nursing schools; support programs for practicing nurses, and projects to improve nursing education. In addition, those schools which meet certain conditions which show that they are carrying out programs calculated to achieve national goals and which receive a special project grant, are provided with an additional sum (calculated as 20 percent of the federal share of the cost of the project) to reward their efforts in the national interest.

CAPITATION

Under existing law, health professions and nursing schools receive grants to support their educational programs. These awards are calculated on a per student basis and thus are called capitation grants. While this program has contributed to institutional stability and may have kept tuitions from increasing more rapidly than they have, the limited amount of monies available for federal activities in the health professions and nursing areas requires priority to be given to programs, such as special projects and loans, which more directly achieve national goals.

STUDENT ASSISTANCE

Existing law provides three forms of financial assistance to health professions students. The first program is the Health Educational Assistance Loan (known as HEAL) program which provides federal loan insurance to guarantee loans made by private banks to health professions students. The maximum interest rate is 12 percent and there is no federal subsidy. This program is not considered a success because the interest rate is too low to stimulate the private loan market and because the accumulation of interest until the student is able to start repayments leads to unconscionably large debts (e.g., $10,000 per year for four years of medical school leads eventually to a 15-year payback of $150,000!). Although there is no hard evidence as of yet, it is often speculated that these large debts will force doctors into more lucrative specialties rather than into primary care. Nurses are not eligible for this program.

There is also currently available a very limited amount of subsidized loan money from the Health Professions Student Loan (HPSL) program and the Nurse Training Student Loan (NSL) program. These are revolving capital funds to which the federal government has contributed the predominant share. Since these funds cover the entire cost of each loan, relatively large amounts of money provide very little support ($10 million in FY '79 provided loans to 8,920 students, but the average loan was only $1,200).

Also available under existing law are two scholarship programs: the Exceptional Financial Need (EFN) Program for first year health professions students and a scholarship grant program run through schools of nursing. Both programs, because they can only meet a fraction of the need, tend to create large and indefensible differences in debt load between individuals in roughly similar circumstances, one of whom receives an award and another who does not. Additionally, the FY '80 appropriation for EFN scholarships of $10 million will provide only about 900 scholarships; no more than 3 to 4 awards for each medical, osteopathic and dental school and about 1 to 2 awards for each veterinary, optometry, pharmacy, and podiatry schools. This is far too little impact for the money involved.

My bill replaces this entire student assistance structure based on four principles: students should be required to pay their own way to the maximum extent possible; assistance should focus on getting students through their school years with manageable debts until they reach the point that they can repay; federal funds should be used as leverage to generate substantial amounts of loan money in the private sector; and student assistance programs should encourage (but not compel) students to enter primary care practices in medically underserved areas.

Accordingly, my bill would establish a two-tiered loan program for most health professions students to permit them to borrow up to $20,000 per year to pay for tuition, educational expenses, and reasonable living expenses. Students with financial need (as determined by their school) would be able to borrow up to their needs at market rates (maximum rate: the lesser of the 91 day Treasury note rate plus 2.5 percent or 15 percent) with a federal subsidy which would reduce the effective rate to 7 percent while the student is in school. Students without need (as determined by the school) or who wished to borrow more than their need to pay expenses, would be able to borrow at market rates (as defined above). Whether the loan is subsidized or not the student would be able to defer payment of interest until after graduation and up to three years of graduate training.

The federal interest subsidy (market rate at the time the loan was made minus the seven percent for which the student is responsible) would continue while the student was in school; for up to two years graduate training for veterinary, optometry, pharmacy, podiatry, public health, and nursing students; for up to three years in primary care graduate training for medical, osteopathic, and dental students; and for other periods including time during which the individual is practicing primary care or is involved in research. When subsidies end, the borrower would be responsible for the full interest rate.

Leverage is an important component of this program. The $20 million authorized for interest subsidies in FY '81 could provide subsidies for $250 million of private sector loans. Further the subsidies, while of modest cost to the government, nonetheless have a significant impact on moderating total debt load and are structured to encourage primary care practice.

The federal government's income from dissolution of HPSL (estimated to be about $16 million or more in FY '81) is proposed to be used as a loan forgiveness fund to partially pay off the student loan debts incurred by certain first year health professions students who do not succeed in making it into their second year and to provide partial loan forgiveness to individuals who choose to practice in medically underserved areas. On one hand this will eliminate an inequity in making all health professions students responsible for the costs of their education: the individual who fails after one year is left with sizable debt and severely reduced prospects for repaying it. On the other hand, loan forgiveness will be used to encourage practice in medically underserved areas and in particular will redeem a commitment that the federal government made to many students during the 1970's that their loans would be all or partially forgiven for practicing in underserved areas.

The NSL Program for nurses would be continued through 1984 and then would be dissolved. Interest would continue to be charged under the program only during the repayment period, but the rate would be increased from 3 percent to 7 percent. Loan forgiveness for certain types of practice would be continued. Because nursing students are undergraduates, much more extensive use should be made by nurses of the Guarantee Student Loan Program (GSLP) and other programs available under the Higher Education Act. The proposed extension of NSL without authorization for new federal capital contributions, is intended to provide the nursing school community with a transition period during which the switch to GSLP as the primary loan source can occur.

SERVICE SCHOLARSHIPS

Existing law provides for a National Health Service Corps (NHSC) Scholarship Program under which students, primarily at schools of medicine and osteopathy, agree to serve in the NHSC in a medically underserved area, one year for each year they receive an NHSC scholarship. The scholarships pay tuition, fees, other educational expenses, and a monthly stipend. Because the students who receive scholarships are primarily physicians with long training years ahead of them, NHSC scholarships recipients in FY '80 will, for the most part, not be available for service until 1987 at the earliest, with commitments for 2 to 4 years service beyond that date. The federal government's need for vast numbers of physicians in federal service in the late 1980's is at best a guess. Given the vast outpouring of doctors now emerging from our nation's schools it is likely that the need will be less than the 5,000 or more doctors who will owe service. In addition, the budgetary cost of having doctors provide health services while employed by the federal government is astronomical and the NHSC service program costs will, within 3 or 4 years, begin to squeeze out dollars vitally needed for other health programs. Further, a civilian federal health corps is generally undesirable and certainly inefficient. Every effort should be made to encourage NHSC scholarship recipients to utilize the private practice option, under which scholarship recipients are released from their federal service obligation if they set up a private clinical practice in a medically underserved area.

For all these reasons, it is proposed to phase the NHSC scholarship program down from the FY '80 appropriation of $85 million to authorizations of $55 million in FY '81 and $35 million in FY '82 and $30 million in FY '83 and FY '84. This should provide adequate manpower for federal service in 1990 and beyond, with particular emphasis to be placed on meeting the needs of the Indian Health Service.

To assist states in becoming more fully involved in solving the health manpower shortage problems within their own areas, including the use of a different mix of practitioners (including physician assistants, nurses, and nurse practitioners) whose service commitments would come due much sooner, a new program is proposed of grants to states to fund service scholarships. In addition to thereby having states absorb the costs of the future service owed by these individuals, this program would hope to take advantage of the greater sensitivity of state governments to local needs and of the likelihood that states would strongly encourage use of a private practice option.

FINANCIAL DISTRESS AND START-UP

Existing law provides for financial distress grants to health professions and nursing schools which are in serious financial distress, and start-up assistance to new health professions schools. My bill establishes two types of financial distress grants for health professions and nursing schools. The first is similar to existing law but available for no more than three years, and can be used for operating costs, accreditation, and carrying out operational, managerial, and financial reforms. The second is an advanced grant, available for up to five years, for schools that have already received financial distress grants under existing law or its continuation. To qualify for advanced grants, the school would be required to have an approved plan to achieve financial solvency with five years and a commitment from a state or local government to match the federal distress grant.

A revised program of start-up assistance grants would be available to schools of veterinary medicine, podiatry, optometry, public health, and nursing. Grants are also authorized for conversion of two-year medical schools to degree-granting institutions.

CONSTRUCTION

Existing law grants, loan guarantees, and interest subsidies for construction of teaching facilities for health professions and nursing schools, and ambulatory primary care teaching facilities for the training of medical, osteopathic, and dental students. This program was designed to encourage enrollment expansion, which is no longer a federal goal. In addition, construction of new facilities for relatively stable enrollments is not cost effective, except in the case of new schools. However, there are a substantial number of health professions and nursing facilities in need of renovation in order to be used in an efficient manner, to carry out initiatives in ambulatory primary care, and to be able to provide students with the most up-to-date scientific experience. Accordingly, except in the case of new schools, no money for new construction would be made available. Instead, funds, primary interest subsidies rather than grants, would be available for renovation, modernization and conversion of existing health professions and nursing facilities for use in teaching and research, and for use as ambulatory primary care teaching facilities for medical, osteopathic, and dental students. To reflect higher current borrowing rates, interest subsidies first made after October 1, 1980 would be increased from 3 percent to 6 percent. In addition, previous recipients of construction grants would be provided with a unilateral release of their contractual obligation to fulfill enrollment increases.

SECTION-BY-SECTION SUMMARY

The proposed Health Professions Educational Assistance and Nurse Training Act of 1980 is divided into two titles, one devoted to the health professions and allied health personnel and the other to nurse training. Although some sections of existing law are reprinted in slightly modified form, the bill represents a substantial revision of programs under Title VII and Title VIII of the Public Health Service Act.

Findings and Declaration of Policy. The Congress finds that geographic and specialty distribution of health personnel continues to be a significant national problem and that it is appropriate for the United States to support the education and training of health professionals, nurses, and allied health personnel in order to encourage better specialty and geographic distribution and to ensure the initial and continuing competency of such professionals, nurses and personnel.

TITLE I—HEALTH PROFESSIONS AND ALLIED HEALTH PERSONNEL

Section 101. Title I may be cited as the "Health Professions Educational Assistance Act of 1980".

Section 102. Title VII of the Public Health Service Act (health professions education) is repealed, except for some existing sections dealing with student loan administration, emergency medical training, and the National Health Service Corps scholarship program.

Section 103. Title VII of the Public Health Service Act is retitled "Training of Health Professions and Allied Health Personnel".

Section 104. The following sections are inserted in Title VII:

Part A—General provisions, Financial distress and start-up grants

Section 700 contains definitions necessary for carrying out this title.

Section 701 establishes a 21 member National Advisory Council on Health Professions and Allied Health Education to advise the Secretary.

Section 702 permits programs under this title to be funded in advance of the authorized year as long as the money is not obligated prior to such year.

Section 703 requires schools, programs, and training centers which receive support under this title to provide assurances that they do not discriminate on the basis of sex or race in admission to their programs.

Section 704 contains records and audit requirements which must be met by recipients of funds or loan guarantees under this title.

Sections 705 and 706 are administrative provisions dealing with the making of grants and contracts.

Section 707 forbids the Secretary from providing support under this title to any school, program or training center which charges higher tuition or fees to certain students solely on the basis that such students are the recipients of traineeships, loans, loan guarantees, service scholarships or interest subsidies from the Federal Government.

Section 708 establishes a uniform health professions data reporting system and authorizes analytic and descriptive studies of such data.

Section 709 places restrictions upon the collection, maintenance, and transmittal of individually identifiable personal data under this title.

Section 710 states that nothing contained in this title shall be construed as authorizing interference in the administrations of educational institutions.

Section 711 creates a program of grants, not to exceed three for any school, to assist schools which are in serious financial distress to meet the cost of operation, to maintain accreditation, and to carry out operational, managerial, and financial reforms.

Section 712 provides for *advanced grants* for schools in serious financial distress that have previously received one or more financial distress grants. Up to five years of support is available under this section provided the school has an acceptable plan to achieve financial solvency within such time and has obtained a commitment for state and local funds to match the Federal distress grant.

Section 713 contains a program of start-up grants for new schools of veterinary medicine, public health, optometry, and podiatry, and grants for conversion of two-year schools of medicine to four-year degree granting institutions. Recipients of start-up assistance under existing law who would have reasonably expected to receive support in FY81, 82, or 83 are permitted to receive such support.

Part B—Student assistance

Subpart I—Student Loans

Section 715 establishes a program of federally insured loans and interest subsidies available to students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, nursing, and public health.

Section 716 limits such loans to full-time students in good standing to help them pay tuition and reasonable educational and living expenses (as determined by the student's schools), and establishes periods during which repayment of principal and interest may be deferred. The maximum interest rate is set at the 91 day Treasury note rate plus 3.5 percent, or 10 percent, whichever is less.

Section 717 establishes a Student Loan Insurance and Interest Payments Fund to pay interest subsidies (as provided in section 718) and defaults.

Section 718 provides that students who have demonstrated financial need for the loans (as determined by their school) shall be entitled during specified periods to an interest subsidy sufficient to reduce the effective interest rate of the loan to the student to seven percent. Interest subsidies are available for such students while in school, for up to three years of residency or advanced training in primary care, for certain periods of practice in primary care or research, and for other specified periods.

Section 719 places limits on the amount a student may borrow under this program. For most health professions students this amount is $20,000 per year and $80,000 aggregate.

Section 720 authorizes appropriations for the Student Loan Insurance and Interest Payments Fund.

Section 721 limits the aggregate amount of all new loans which may be insured in any year, starting at $250 million in FY 81 and increasing in subsequent years.

Section 105. The following sections are inserted in Title VII.

Subpart II—Loan Forgiveness

Section 727 provides for a loan forgiveness program to discharge part of the loan liabilities incurred by certain health professions students, graduates, and former students while they were in a health professions school.

Section 728 establishes a Student Loan Forgiveness Fund to provide monies for the loan forgiveness program.

Section 729 specifies which individuals may receive loan forgiveness, and sets out priorities if insufficient funds are available. Partial loan forgiveness may be made to, or on behalf of, individuals who: die or become permanently and totally disabled; fail to complete their first year of health professions school; or practice their health profession in a medically underserved area.

Section 729A provides for a capital distribution of the funds in each school's Health Professions Student Loan Fund, with the federal share of such funds to be deposited in the Student Loan Forgiveness Fund under section 729.

Part C—Special projects

Subpart I—General

Section 730 authorizes the Secretary of Health and Human Resources to make special project grants and contracts to health professions schools and other entities and directs the Secretary, in calculating the amount of each grant or contract under this part made to a health professions school providing certain assurances under section 771, to add to the federal share of the cost of carrying out the project an amount equal to 20 percent of such federal share of the cost, to be used for educational purposes.

Section 731 describes the conditions which schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health and allied health and graduate programs in health administration must meet in order to receive the added monies described in section 730.

Subpart II—Graduate Training and Specialty Distribution

Section 735 provides for grants for physician residency training programs and traineeships in the primary care fields of general internal medicine, general pediatrics, and family medicine.

Section 736 contains grants for dental residency training programs and traineeships in the general practice of dentistry.

Section 737 authorizes grants to schools of medicine and osteopathy for projects to establish and maintain or improve departments of family medicine.

Section 738 establishes grants for schools of medicine, osteopathy and public health to develop and maintain physician residency programs in preventive medicine, and for schools of medicine and dentistry to develop and maintain physician residency programs in physical medicine and rehabilitation.

Section 106. There is inserted in Title VII the following:

Subpart III—Improving Geographic Distribution

Section 740 provides for grants to schools of medicine and osteopathy to plan, develop, and operate area health education centers.

Section 741 creates a program of grants to health professions schools to assist in the cost of projects to provide clinical training in remote sites which serve medically underserved populations.

Section 742 contains a program of grants to schools of medicine, osteopathy, and dentistry for projects to provide support services to physicians and dentists practicing in medically underserved areas.

Subpart IV—Training and Curricular Development

Section 745 authorizes grants for the training of physicians assistants and expanded function dental auxiliaries, and for cooperative interdisciplinary training among health professions students, including multiple auxiliary teams.

Section 746 provides special projects for schools of allied health and traineeships for advanced training of allied health personnel for teaching, administrative, and supervisory positions.

Section 747 contains special projects for schools of public health, graduate programs in health administration, and other post-baccalaureate programs in these fields and traineeships for students at such schools and programs.

Section 748 authorizes grants to strengthen the clinical training provided to students in schools of veterinary medicine, optometry, pharmacy, and podiatry.

Section 749 establishes grants to health profession and allied health schools to develop courses and innovative teaching methods in health care policy and health care economics.

Section 750 creates grants for health professions and allied health schools for evaluating continuing education and developing innovative approaches to providing such education.

Section 751 provides grants to health professions and allied health schools to demonstrate methods of reducing the total cost of education in such schools without impairing quality.

Section 752 authorizes grants to health professions schools to develop and expand curriculum offerings in geriatrics, diet and nutrition, public health, occupational and environmental health, disease prevention and health promotion, physical health and rehabilitation, toxicology, and animal and human nutrition.

Subpart V—Student diversity

Section 755 contains a grant program for recruitment, counseling, and support services for individuals from disadvantaged backgrounds who are entering or planning to enter into a health career.

Part D—Service scholarships

Subpart I—Grants to States for Service Scholarships

Section 760 establishes a federal program of grants to states to fund the cost of service scholarships offered by the state to health professions students.

Section 761 specifies certain minimum requirements for the expenditure by states of monies provided under section 760, including the required service commitment, penalties and other aspects of a service scholarship agreement between a state and a service scholarship recipient.

Section 762 sets out a formula for the allocation of grant money to the states for service scholarships.

Section 107. There is inserted in Title VII the following:

Part E—Grants, loan guarantees, and interest subsidies for conversion, renovation, and construction of teaching and research facilities for medical, dental and other health personnel

Section 775 establishes a program of grants for: renovation, modernization, or conversion of existing facilities for use as teaching and research facilities at health professions schools, conversion of existing facilities for use as ambulatory primary care teaching facilities for physicians and dentists, and construction of teaching and research facilities at new health professions schools which meet certain criteria.

Sections 776, 777, and 778 set out administrative provisions dealing with applications for grants under section 775 including limits on the amount of any grant and recapture of payments by the federal government under certain circumstances.

Section 779 provides previous recipients of construction grants with a unilateral release of their contractual obligations to fulfill enrollment increases.

Section 780 contains a program of loan guarantees and interest subsidies to health professions schools to carry out the same type of projects for which grants are authorized under section 775.

Section 108. This section contains conforming amendments. Sections from existing law which deal with administration of student loans, the National Health Service Corps Scholarship program, and the National Health Service Corps service program are retained with amendments.

Section 109. The amendments made to Title VII are effective October 1, 1980.

TITLE II—NURSE TRAINING

Section 201. Title II may be cited as the "Nurse Training Act of 1980."

Section 202. Title VIII of the Public Health Services Act (dealing with nurse training) is repealed. A new Title VIII is proposed as follows:

Part A—General provisions; financial distress and start-up grants

Section 800 contains definitions necessary for carrying out this title.

Section 801 establishes a 19 member National Advisory Council on Nurse Training to advise the Secretary.

Section 802 permits programs under this title to be funded in advance of the authorized year as long as the money is not obligated prior to such year.

Section 803 requires schools which receive support under this title to provide assurances that they do not discriminate on the basis of sex or race in admission to their programs.

Section 804 provides records and audit requirements which must be met by recipients of funds or loan guarantees under this title.

Sections 805 and 806 are administrative provisions dealing with the making of grants and contracts.

Section 807 forbids the Secretary from providing support under this title to any school which charges higher tuition or fees to certain students solely on the basis that such students are the recipients of loans, loan guarantees, service scholarships or interest subsidies from the federal government.

Section 808 establishes a uniform nursing data reporting system and authorizes analytic and descriptive studies of such data.

Section 809 places restrictions upon the collection, maintenance, and transmittal of individually identifiable personal data under this title.

Section 810 states that nothing contained in this title shall be construed as authorizing interference in the administrations of educational institutions.

Section 811 creates a program of grants, not to exceed three for any school, to assist schools which are in serious financial distress to meet the cost of operations, to maintain accreditation, and to carry out operational, managerial, and financial reforms.

Section 812 provides for advanced grants for schools in serious financial distress that have previously received financial distress grants. Up to five years of support are available under this section provided the school has an acceptable plan to achieve financial solvency within such time and has obtained a commitment for state or local funds to match the federal distress grant.

Section 813 contains a program of start-up grants for new schools of nursing.

Part B—Student loans

Section 820 provides for the continuation of the Nurse Training Student Loan Fund.

Section 821 stipulates that loans from the fund to any student may not exceed $2500 per year or $10,000 aggregate, establishes periods for repayment and deferral of payment, sets the interest rate on the loan during repayment at 7 percent per annum, and continues existing provisions relating to loan forgiveness.

Section 822 provides for a distribution of the assets of the Nurse Training Student Loan Fund after September 30, 1984.

Part C—Special projects

Section 830 authorizes the Secretary of Health and Human Services to make special project grants and contracts to schools of nursing and other entities and directs the Secretary, in calculating the amount of each grant or contract under this part made to a school of nursing providing certain assurances under this section, to add to the federal share of the cost of carrying out the project an amount equal to 20 percent of such federal share of the cost, to be used for educational purposes.

Section 831 provides grants to collegiate schools of nursing to develop, expand, or maintain programs for the advanced training of nurses.

Section 832 provides grants to schools of nursing to develop, expand, or maintain programs to train nurse practitioners.

Section 833 provides grants to schools of nursing for traineeships for participants in programs of advanced nurse training, including nurse practitioner programs.

Section 834 contains grant authority for programs to recruit, counsel, and provide support services to individuals from disadvantaged background who are entering or considering a career in nursing.

Section 835 authorizes grants for schools of nursing to develop and expand curriculum offerings in health policy and health care economics, maternal and child health, geriatrics, diet and nutrition, and public health and public health education.

Section 836 provides authority for grants to schools of nursing to develop and implement programs which provide support for practicing nurses, such as continuing education and retraining for nurses re-entering the job market.

Section 837 establishes a grant and contract program for schools of nursing for the improvement of nursing education, such as clinical training for collegiate nursing students, reducing the costs of nursing education, and research in nursing education.

Part D—Grants, loan guarantees, and interest subsidies for renovation and construction of teaching facilities for nurses

Section 840 establishes a program of grants for: construction of teaching facilities at new nursing schools; and renovation, modernization, or conversion of existing facilities for use as teaching facilities at nursing schools.

Sections 841, 842, and 843 set out administrative provisions dealing with applications for grants under section 840, including limits on the amount of any grants, and recapture of payments by the federal government under certain circumstances.

Section 844 provides previous recipients of construction grants with a unilateral release of their contractual obligations to fulfill enrollment increases.

Section 845 contains a program of loan guarantees and interest subsidies to nursing schools to carry out the same type of projects for which grants are authorized under section 840.

Section [illegible]. The amendments made to Title VIII are effective October 1, 1980.

PROPOSED AUTHORIZATIONS—TITLES VII AND VIII OF THE PUBLIC HEALTH SERVICE ACT

[In millions of dollars, fiscal years]

	1980 comparable appropriation	Authorizations 1981	1982	1983	1984
Health professions data (new sec. 708)	[illegible]	[illegible]	[illegible]	[illegible]	5.5
Financial distress grants (new sec. 711)	5.0	5.?	5.?	5.?	5.5
[illegible] financial distress (new sec. 712)		5.0	5.0	5.0	5.0
Start-up (and conversion) assistance (new sec. 713)	2.7	4.0	4.?	4.?	4.5
Student loan subsidies (new sec. 730)		20.?	41.?	40.?	40.5
Primary care training (includes family medicine) (new sec. 7??)	56.?	80.?	85.?	90.?	95.0
General dentistry training (new sec. 780)	4.0	[illegible]	[illegible]	[illegible]	9.5
Departments of Family Medicine (new sec. 7??)	9.5	12.?	13.?	15.?	15.?
Preventive medicine and physical rehabilitation medicine training (new sec. 7??)		7.6	8.5	10.?	11.5
Area health education centers (new sec. 7??)	21.0	[illegible]	[illegible]	[illegible]	48.0
Remote site training (new sec. 7??)		5.5	7.0	8.?	10.0
Support services in underserved areas (new sec. 7??)		5.5	7.0	7.5	15.0
[illegible] interdisciplinary (new sec. 7??)	21.4	[illegible]	[illegible]	[illegible]	[illegible]
Projects and training for allied health (new sec. 7??)	10.0	15.?	17.?	19.?	21.0
Projects and training for Public health and health administration (new sec. 7??)	14.0	25.0	27.0	28.?	29.0
Clinical training for [illegible] schools (new sec. [illegible])		17.0	15.0	15.0	18.0
Health care policy and economics (new sec. 7??)		5.?	6.0	7.0	8.0
Continuing education projects (new sec. 7??)		5.0	6.0	7.0	8.0
Educational cost projects (new sec. 7??)		[illegible]	4.0	7.0	4.0
Curriculum development (new sec. 7??)		[illegible]	8.5	10.0	1.0
Disadvantaged assistance programs (new sec. 7??)	19.6	25.0	27.?	28.0	29.0
Grants to States for service scholarships (new sec. 7??)		40.0	50.0	60.0	70.0
National Health Service Corps scholarships (new sec. 7??)	81.5	91.0	95.0	90.0	90.0
Construction grants (new sec. 77?)	1.5	3.0	3.0	3.0	3.?
Construction interest subsidies (new sec. 7??)	8.?	8.0	9.0	10.0	11.0
Nurse training—Continuing programs only (see following sheet)	53.0	97.0	107.75	117.5	127.0
HPE and NT programs—Not reauthorized and program support	192.5				
Title VII and VIII total	402.4	522.0	572.75	635.0	702.0

PROPOSED AUTHORIZATIONS—TITLE VIII—NURSE TRAINING ACT

[In millions of dollars, fiscal years]

	Fiscal year 1980 appropriation under continuing resolution	Authorizations 1981	1982	1983	1984
Nursing data (new sec. 805)		1.0	1.25	1.5	1.5
Financial distress grants (new sec. 811)		1.0	1.0	1.0	.5
Advanced financial distress grants (new sec. 812)		1.0	1.0	1.0	1.0
Start-up assistance (new sec. 813)		1.0	1.0	1.0	1.0
Advanced nurse training projects (new sec. 831)	12.5	20.0	22.0	24.0	26.0
Nurse practitioner programs (new sec. 832)	13.0	20.0	22.0	[illegible]	25.0
Advanced NP traineeships (new sec. 833)	15.0	20.0	22.0	[illegible]	26.0
Disadvantaged assistance projects (new sec. 834)	15.0	2.0	2.5	3.0	3.0
Curriculum development (new sec. 835)		6.0	7.0	8.0	9.0
Support for practicing nurse (new sec. 836)		10.0	11.0	12.0	13.0
Improvement of nursing education (new sec. 837)		12.0	13.5	14.0	15.0
Construction grants (new sec. 840)		1.0	1.0	1.0	1.0
Construction interest subsidies (new sec. 845)		2.0	2.5	3.0	3.5
NT programs not reauthorized	47.3				
Total	100.3	97.0	107.75	117.5	127.0

Miscellaneous special projects.

[From the Congressional Record—Senate, March 4, 1980]

Introductory Statement of Mr. Javits on S. 2378

By Mr. JAVITS (for himself, Mr. WILLIAMS, Mr. KENNEDY, and Mr. METZENBAUM):

S. 2378. A bill to amend title VII of the Public Health Service Act to provide grants and fellowships for health care management, to provide grants for special projects to encourage geographic and speciality distribution of physicians, to amend the Immigration and Nationality Act with regard to alien graduates of foreign medical schools, and for other purposes; to the Committee on Labor and Human Resources.

HEALTH CARE MANAGEMENT AND HEALTH CARE PERSONNEL DISTRIBUTION IMPROVEMENT ACT OF 1980

Mr. JAVITS. Mr. President, I am pleased to introduce today along with Senators WILLIAMS, KENNEDY, and METZENBAUM the Health Care Management and Health Care Personnel Distribution Improvement Act of 1980. The purpose of this bill is: First, to address the critical need to improve management in health care; and second, to improve the geographic and speciality distribution of health professionals by focusing on such influential factors as the residency training experience and reimbursement policies.

TITLE I—HEALTH CARE MANAGEMENT IMPROVEMENT

Mr. President, I believe that the quality of health care falls far short of its potential. Examples of severely mismanaged health care facilities—hospitals, long-term care facilities, ambulatory care clinics and other facilities—are familiar to us all. Management indisputably plays a crucial role in determining the cost, quality, availability and accessibility of health care services; unfortunately, I believe we have not recognized this role and have neglected to give management the attention it deserves.

For too long, management in health care has been viewed as an activity which takes away dollars from services. It is time to abandon this notion. As this Nation places increasing emphasis on controlling health care costs and improving the allocation of health care resources, it is critically important that we make certain that the health care delivery system is supported by a solid management foundation.

The fundamental goal of the health care system is to provide high quality health care services without discrimination as to financial status, but no one can deny that health care is also big business. Health care is the third largest economic sector in the United States. Hospitals alone employ over 3 million people and maintain assets of over $80 billion. In 1978, $192 billion was spent on health care in this country—9.1 percent of the gross national product. This year, estimates indicate that health care expenditures will exceed the $245 billion mark. We must seek to assure that this major component of our economy is operating as efficiently as possible—this can only improve our ability to attain our goals.

With respect to the health care system as a whole, we hear from many sources within the field that it is undermanaged, ill managed, or at worst, not managed at all; and, with respect to the individual organizational unit—the hospital, the nursing home, the HMO, the community or migrant health center, the fee-for-service group practice—we hear that there is wide variation in how well those organizations are managed. Moreover, health care lags behind other major industries in terms of its applications of important modern management skills such as finance, marketing, organizational development and economics.

I believe that this situation is largely related to the historical development of our health care system. The responsibility for the delivery of medical services in this country traditionally has been the province of the individual practitioner. In general, there has been little, if any organized relationship between practitioners. Today, this country has approximately 6,600 hospitals—of which about half have fewer than 100 beds—20,000 nursing homes, 8,400 group practices, 212 HMO's and other prepaid group practices, and 245,000 solo practitioners. There are also scores of nurses, social workers, psychologists, physical therapists and other health-related providers. While physicians have moved toward group practices and hospitals have begun to undertake shared services arrangements, the principal participants in the health care field continue to operate independently.

Over time, our health care system has changed dramatically in terms of its sophistication and complexity. The investment of significant resources in biomedical research during the past four decades—which I strongly supported and intend to continue supporting—produced a tremendous technological explosion which manifested itself in the development and production of highly sophisticated equipment, drugs, devices, treatment modalities and highly specialized medical manpower. Additional investment of substantial resources in manpower training and facilities development led to the training of large numbers of health care providers and the establishment of thousands of hospitals and other health care facilities.

From a managerial point of view, this technological explosion placed rigorous demands on hospitals and other health care delivery organizations. Accommodating the new technology called for new staffing patterns, expansion of facilities, and the purchase of sophisticated equipment. Many facilities, particularly small hospitals, were ill prepared to deal with the new organization requirements. This was due in part to the absence of adequately trained administrators and managers with the new, complex arrangements. While this situation has improved considerably, as recently as 1975 the Kellogg Foundation's Commission on Education for Health Administration concluded that "fewer than 25 percent of executive level positions in the health and medical care system are filled by individuals who have had formal entry-level education in health administration."

Effective management in health care also has been made more difficult by the presence of such unique characteristics of the health care industry as the third party payment system and the traditional provider/consumer relationship which finds the provider largely in control of the provision of services. Such characteristics call for the development of unique management skills to deal with these important and influential factors.

Concern about the quality of management in health care has manifested itself indirectly in a variety of ways in recent years. For example, both the public and private sectors have responded to criticism that there is waste and inefficiency in health care by developing, and in some States, implementing proposals to trim excess capacity, reduce hospital expenditures, and encourage greater attention to efficiency.

The recent enactment of major pieces of legislation such as the Health Planning Development Act, the Professional Standards Review Organization (PSRO) Act, and the Health Maintenance Organization (HMO) Act can be seen as Federal attempts to redress this problem. The growing acceptance of second opinions; the movement toward outpatient, ambulatory services and away from expensive inpatient services; the increasing emphasis on enhancing competition in the health sector; the development of capable, less costly providers of health care like physician assistants and nurse practitioners; and the movement toward shared-service arrangements among hospitals are manifestations of the concern that the health care system can be managed better. The time has come, however, to confront directly the question of poor management in health care; I am convinced that a concerted effort by the public and private sectors to improve management would improve the cost, quality, and availability of health care services.

Mr. President, the bill I am introducing today represents a modest but wise investment of Federal dollars into this critical problem. The bill contains the following four major components:

PROGRAMS IN HEALTH ADMINISTRATION

First, the bill continues existing support to programs and students of health administration while requiring needed curriculum improvements and providing support for curriculums and faculty development in management disciplines determined to be in short supply in health administration programs. I believe that there is ample justification for continuing Federal support to health administration programs. According to the Department of Labor, 160,000 health services administrators representing all managerial levels were employed in 1976; by 1985, the requirement for such administrators is expected to rise to 230,000. In an effort to meet this need, the bill extends the enrollment increase policy established in 1975. Today, there are 36 of these programs which graduate approximately 1,500 students per year.

The bill also provides support for faculty and curricula development. The Association of University Programs in Health Administration (AUPHA) reports inadequate or unavailable courses and a serious shortage of qualified faculty in such critical disciplines as health services finance, health planning and epidemiology, marketing, economics, health law, in formation systems management, ambulatory care management, and quality assurance and assessment.

The bill replaces the existing authority for grants to accredited programs in health administration for traineeships for students in such programs with a new authority for grants to programs in health administration for providing fellowships to such students. Under the new provision, 3 year fellowships shall be awarded to health administration students provided that the program agrees to arrange for at least 1 year of supervised experience for the recipient in such facilities as hospital-affiliated primary care centers, community or migrant health centers, HMO's, community mental health centers, official State or local public health agencies, health planning agencies, public or private nonprofit hospitals located in a medically underserved area or facilities owned or operated by the U.S. Public Health Service or the Indian Health Service.

The purpose of this provision is to expose health administration students to the management requirements of these important facilities and to permit such facilities—which often desperately need well-trained managers—to reap the benefits of the management expertise held by the fellowship recipient.

HEALTH CARE MANAGEMENT TRAINING PROGRAMS FOR HEALTH CARE MANAGERS AND PROVIDERS

Second, the bill provides support for management training programs for physicians, nurses, other providers of health care, managers, and administrators who occupy leadership positions in health care facilities. As noted earlier, the Kellogg Foundation determined only a few years ago that fewer than 25 percent of individuals in executive level positions in the health care system have formal entry-level education in health administration. Moreover, the American Medical Association estimates that as of August 1978, more than 12,000 physicians identified administration as their major professional activity. The American Nurses Association estimates that approximately 45,000 nurses occupy administrative or managerial positions, but that only 20 percent have had formal preparation in management. There is a critical need to expose such individuals to the most current management skills in order to assure their effectiveness in these vital roles.

RESEARCH AND DEMONSTRATION IN HEALTH CARE MANAGEMENT

Third, the bill calls for research and demonstration projects in health care management. Such projects would focus on identifying and transferring management skills utilized in other industries to the health care industry, demonstrations involving new forms of health care delivery and other projects which will lead to improved management in health care.

REPORT

Finally, the bill calls for a comprehensive study of the quality of management in health care and recommendations for ways to strengthen and improve it. In my judgment, this report is one of the most important provisions of the bill. Although we are all aware of instances of managerial shortcomings and failures in specific health facilities, virtually no solid data exists. My legislation would authorize the HHS Secretary to contract for this essential study. My intent here is not to have the Government evaluate the private sector, but for this study to be conducted by organizations or individuals who are most expert in the field of management.

TITLE II—HEALTH CARE PERSONNEL DISTRIBUTION IMPROVEMENT

Mr. President, title II of my bill seeks to improve the geographic and specialty distribution of health professionals by focusing on such influential factors as the residency training experience and reimbursement policies.

SPECIAL PROJECTS FOR RESIDENCY TRAINING

In response to a perceived critical shortage in health personnel throughout the Nation, the Congress enacted legislation in 1963 to provide direct Federal support tied to enrollment increases for health professions education. Between 1963 and 1973, enrollment in medical schools increased from 8,772 to 14,034. Enrollment in other health professions schools (ODVOPP) similarly almost doubled.

In 1976, the Congress recognized and began addressing the problems of geographic and specialty distribution of health practitioners which left many Americans without adequate health care services. Start-up assistance was provided for new medical schools whose goal was to produce primary care physicians. Support was provided for increased National Health Service Corps scholarships to assist students with career goals in primary care practice to attend medical school in return for providing medical service in an underserved area after graduation.

Residency training programs in family medicine and general internal medicine and general pediatrics were supported to provide innovative graduate medical education opportunities for physicians seeking primary care specialty training. Curriculum initiatives to provide undergraduate student primary care preceptorship experiences in the community were sponsored to help reinforce the primary care career goals of some students.

As a result of these and other initiatives, significant progress has been made. The number of family practice residency programs has increased from 15 in 1969 to 364 in 1979 and the number of family practice residents has increased from 290 in 1970 to over 6,000 in 1979. More than 60 general pediatric and general internal medicine residency programs have been developed and 50 percent of first year residency positions in teaching hospitals affiliated with medical schools are in primary care specialties of internal medicine, pediatrics, and family practice. Yet, despite this progress, only 38 percent of active physicians are in primary care specialties and this is not expected to change dramatically until after 1985.

Furthermore, the Department of Health and Human Services estimates that 50 million people still live in areas designated to be medically underserved. Therefore, I believe that we must continue and further strengthen our efforts to train health professionals who are prepared to provide medical care to underserved populations.

There is increasing evidence that the backgrounds of individual medical students, the way in which they finance their medical education and their educational preparation have an impact on specialty choice and geographic location of practice. Yet most Federal efforts focus on undergraduate medical education.

Medical education must be viewed as a continuum beginning with the premedical preparation of the student and continuing throughout the practicing life of the physician. While great attention has been paid to the undergraduate period of medical school and increasing attention to continuing medical education, physician practice patterns are influenced greatly during the graduate medical education or residency training period. According to a 1979 report of the Task Force on Graduate Medical Education of the Association of American Medical Colleges:

> Graduate medical education has become as important as undergraduate medical education in the preparation of physicians . . . It shapes the career of medical school graduates and determines the spectrum of qualified specialists that will be available.

The residency training period is perhaps one of the most influential periods in the determination of the future location, quality, and style of a physician's practice, yet we are not taking full advantage of the opportunities provided by this segment of the educational process to achieve national objectives.

One of the major factors which inhibit changes in the content of residency training programs is how residency education is financed. The major costs of residency education are financed by third party reimbursement to the hospital as over 80 percent of a resident's time is spent in direct patient care.

However, because the current reimbursement system provides primarily for inpatient care and procedure-oriented ambulatory care, this approach has a clear influence on the way patterns of hospital services have developed and, consequently, on the kinds of patient care experiences which dominate the resident's education. This results in little training in primary care in the ambulatory setting and little or no opportunity for hospital based residents to have a practice experience outside the hospital walls in the communities in which they will practice. This also makes educational experiences which are not traditionally part of highly technical patient care procedures very difficult. Thus, little attention is paid to the psychosocial aspects of patient care, or the ethical or human values questions raised daily in the intense hospital environment which often involve life and death decisions.

Residents also receive little or no formal instruction in the organization of the health care delivery system or the particular needs of the communities in which they will practice upon completion of their training. Finally, although residents play a major role as teachers of medical students and junior house staff, this is a role for which they are usually unprepared.

Despite the obstacles, there is clear justification for supporting appropriate changes in the residency training experience. Data has shown that the geographical location of residency training is significantly related to the area in which physicians eventually choose to practice. Similarly, studies indicate that community-based practice experiences and exposure of residents to other physicians who practice in underserved areas and support a broader, primary care approach to patient needs also can have an impact on the resident physician's choice of practice location, stability in that location, type of practice, and style of practice.

One of the important issues affecting cost, quality, and effectiveness of physician practice is the ability to communicate with the patient—to understand the nature of patients' problems and educate the patient about their illness. Poor communication results in repeated, often unnecessary, utilization of the health care system. Data also indicates overuse of expensive, technical diagnostic procedures because the physician fails to understand the nature of the patient's illness.

Technological advancement in medicine has been a costly, but powerful force for improvement of our ability to diagnose and treat disease. Its very power, however, has created increasing dilemmas about its use. The consequences of such decisions—as whether or not to resuscitate defective newborns, whether or not to initiate and maintain life support efforts on the critically and terminally ill, how to decide on allocation of resources in times of scarcity—not only have tremendous cost implications for our health care system, but also moral and ethical implications. Increasingly, health professionals are expected to make such decisions without appropriate preparation.

Finally, some educators note that the majority of a medical student's clinical education is provided by graduate physicians (residents) in hospitals. Rarely are residents prepared for this teaching role. Improvement in the resident's effectiveness as a teacher will have obvious positive effects on the quality and style of clinical training of the medical students.

The Congress already has taken steps to remedy some of the deficiencies in resident education through its support of residency training programs in family practice and general internal medicine and general pediatrics. However, to be eligible for funds, these programs require a unique structuring of residency schedules which is not always possible for the more traditional programs, even those in the primary care specialties. Thus, residents in traditional programs, still the predominant numbers in training (family practice and federally-funded general internal medicine and general pediatric programs represent fewer than 500 of the over 5,000 graduate programs existing in 1,700 hospitals and facilities in the United States) cannot take advantage of the educational innovation possible through the grant support of these special programs. In order to increase the opportunity for a larger number of residents to have access to educational experiences specifically designed to increase the likelihood of an individual pursuing a satisfactory primary care practice in a medically underserved area, my bill provides support for:

Preceptorships for residents in settings located in medically underserved areas and health manpower shortage areas;

Increasing exposure to physician role models with experience in primary care practice in underserved areas;

Special propects to inform residents about practice in underserved areas and the problems and opportunities associated with such practice.

In addition, the bill provides support for innovative educational programs to increase the amount of residency training located in ambulatory care settings in teaching hospotals or in organised ambulatory care settings affiliated with teaching hospitals.

Finally, in order to improve the quality, cost effectiveness, and appropriateness of patient car, my bill provides support to develop, implement and evaluate educational programs for residents in: The social and behavioral sciences, humanities, ethics and human values, the organization and financing of health care delivery, and cost containment and epidemiology, all as applied to direct patient care. In addition, the bill provides support for special training for residents to better prepare them for their role as clinical teachers of medical and other health professions students.

Through these efforts, I believe that further progress can be made in overcoming problems of specialty and geographic maldistribution, thereby assuring the availability and accessibility of needed health care services to all Americans provided by highly skilled and sensitive practitioners.

[illegible]

Since 1974, the Congress has focused more of its resources toward increasing the numbers and types of health professionals available to assure the delivery of primary care services to medically underserved rural and urban areas. Educational changes have resulted in dramatic increases in the numbers of primary care residencies in family practice, general internal medicine, and general petiatrics. Scholarship assistance to students with the goal of primary care practice and support for health professionals through the National Health Service Corps have increased the availability of health professionals in many of these medically underserved and health manpower shortage areas. These efforts must be maintained if we are to realise our goal of adequate health services for all Americans.

However much attention we pay to factors which influence geographic and specialty distribution during the training period, we would be remiss not to recognize the very important role of the reimbursement system in such choices. It is incumbent upon us to understand how the reimbursement system affects the content, location, style and cost of physician practice and what changes should be made to achieve better disdistribution of health personnel and more appropriate health services.

Recognizing this need in 1973, the Senate Finance Commitee and the House Committees on Ways and Means and Interstate and Foreign Commerce mandated a report to be conducted by the Institute of Medicine, National Academy of Sciences pursuant to section 15(c) of the Social Security Act Amendments of 1973 (Public Law 93-233). Among its other goals, this study was charged to determine. First, the extent to which funds expended in teaching hospitals under titles XVIII and XIX of the Social Security Act are supporting the training of medical specialties which are in excess supply; and second, how such funds could be expended in ways which support more rational distribution of physician manpower, both geographically and by specialty distribution.

In March 1976, the Institute submitted its report and recommendations to the Congress. The recommendations included the following:

Financing mechanisms should be changed to provide more equitable support for ambulatory care services so that medical schools and teaching hospitals would find it easier financially to support primary care training programs; and

A major study should be undertaken to reexamine the basis of physician fees and fee allowances in public and private health insurance programs, with an eye to eliminating inequities in reimbursement by specialty, type of service, and geographic location of practitioner.

Subsequently, a variety of studies, including the 1978 report of the Institute of Medicine, "A Manpower Policy for Primary Health Care," have reiterated these recommendations with even more specific language and included the need to examine the impact of reimbursement on the cost-effective use of nonphysician providers in primary care settings. As a result of the Surgeon General's recent report, "Healthy People," and the proposed national health planning goals, we must add to this list of concerns the effect of reimbursement on the provision of disease prevention and health promotion services in the primary care setting.

Some limited experiments have been conducted to test the real impact of these recommendations. They have, however, been insufficient in number and scope to provide us with the information necessary to make decisions about the operational and economic feasibility of changing the current reimbursement system to reinforce incentives for providing the appropriate kinds of health services in medically underserved rural and urban areas.

It is for this purpose that my bill requires the Secretary to undertake and support research and demonstration programs to lead to appropriate changes in Federal health care reimbursement policies to encourage: First, individuals to enter careers in undersupplied physician specialties and other undersupplied health professions; Second, health personnel to practice in health manpower shortage areas or medically underserved areas; and Third, the training of graduate physicians in ambulatory care settings.

FOREIGN MEDICAL GRADUATES

Mr. President, my bill also contains a provision which is designed to avert a potential crisis in those hospitals which, over the years, have developed a significant dependence on alien foreign medical graduates to fill residency training positions.

BACKGROUND

In response to a perceived shortage of physicians in the 1960s, the Congress adopted amendments to the Immigration and Nationality Act in 1965 which permitted large numbers of FMG's (approximately 7,400 per year) to immigrate to the United States by exempting foreign physicians from the origins quota system. Over time, many inner-city hospitals developed a significant dependence on FMG's because they found it easier to attract FMG's than U.S. medical graduates into their training programs.

In 1976, the Congress amended the immigration laws to restrict the flow of FMG's into this country for two reasons: First, data suggested that U.S. medical schools had expanded sufficiently (in response to capitation incentives) to produce enough physicians to meet projected supply requirements; second, the United States was criticised for causing a "brain-drain" in foreign countries because many of the best foreign physicians were coming to the United States. The 1976 amendments essentially placed foreign medical graduates on the same footing as any other alien trying to enter the country. The law raised the educational requirements for FMG's, stressing proficiency in basic medical science and English, and eliminated the favored status of foreign medical graduates and the occupational preference entitling them to immigrant visas. Foreign medical graduates are now required to enter the United States on exchange visas (for educational purposes) which, unlike immigrant visas, cannot be converted to allow permanent residence.

The 1976 amendments also included provisions which permitted the HEW Secretary to waive the new restrictions for hospitals which could demonstrate that the loss of FMG's would substantially disrupt the hospital's ability to deliver services ("substantial disruption" provision). A hospital receiving such a waiver should continue to bring FMG's into its residency programs while devising alternative ways of attracting health professionals.

Unfortunately, the transition period provided in the 1976 amendments has not been successful. Today, many hospitals still are relying heavily on foreign medical graduates. For example, according to a report recently issued by the New York City council president, FMG's occupy more than 50 percent of housestaff positions in 18 hospitals in New York City; furthermore, almost 41 percent of the housestaff positions at the Health and Hospitals Corporation hospitals'—New York City's municipal hospital system—are occupied by FMG's. Given this situation, I believe that it is unrealistic to expect these hospitals to overcome this problem by themselves. I believe we will achieve our goal of reducing dependence on FMG's only if there is a cooperative effort by Federal, State and local governments and the affected hospitals. My bill seeks to foster this important partnership by:

First. Extending the waiver authorities for 5 additional years (through 1985).

Second. Requiring the HHS Secretary to: First, identify those States in which there are hospitals with accredited residency training programs in which more than 25 percent of the positions are filled by FMG's; and second, develop a plan in cooperation with the State and appropriate municipalities to reduce dependence on FMG's.

Third. Requiring each hospital receiving waivers to develop a staffing plan based on the services it provides.

Fourth. Calling for National Health Service Corps personnel to assist in reducing dependence on FMG's by:

First, permitting NHSC scholarship recipients to fulfill their service obligations by voluntarily performing their residency in a hospital which has a heavy reliance on FMG's; and

Second, designating such hospitals as highest priority health manpower shortage areas for purposes of assigning NHSC personnel, and limiting the cost-sharing responsibilities of the hospitals receiving Corps members to a salary equal to that which was paid to the FMG if the hospital can show that the Corps member replaces an FMG.

Mr. President, while I believe that the United States has an obligation to share our medical knowledge and expertise by offering education and training to foreign medical graduates, I remain committed to the policy adopted by the Congress in 1976 which calls for reducing the country's dependence on FMG's. I believe my bill will do much to move us closer to this goal, yet will insure that no serious disruption of services occurs in the shortrun in institutions which provide badly needed services to many people.

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT AND NURSE TRAINING ACT AMENDMENTS OF 1980

Mr. President, I am pleased also to cosponsor the Health Professional Educational Assistance Act and Nurse Training Act Amendments of 1980 introduced today by Senator KENNEDY. I have worked closely with Senator KENNEDY in the development of this bill and feel that it responds appropriately to current national needs and objectives such as improving the geographic and specialty distribution of health practitioners, encouraging greater minority representation in the health professions and making many needed changes in health professions student assistance programs.

I would like to comment briefly on several sections of the bill which I feel are of particular significance.

The first is that of institutional assistance to the health professions schools. Congress first entered into a partnership with the institutions providing health professions education in 1963 in a move designed to overcome perceived critical shortages of health practitioners. Financial support from the Federal Government assisted efforts by these institutions to meet the country's quantitative health manpower needs. More recently, with the Health Professions Educational Assistance Act of 1976, we continued that partnership in order to increase the supply of professionals providing primary health care services. Senator KENNEDY's proposal recognizes the value of this historical partnership in continuing to meet our Nation's changing health manpower needs. The proposal effectively balances the need to be fiscally responsible in this time of increasingly limited resources with the need to do whatever possible to overcome remaining barriers which prevent our citizens from obtaining high quality health care services.

I support proposed changes in the student assistance provisions for health professions students. These are needed to assure that qualified students will not be denied access to a medical or other health professions education because of their socioeconomic status. I support the use of a variety of payback options for such support which are consistent with societal needs and sound academic and economic principles. I also endorse the new and continued special project provisions for medical and other health professions students which continue to reenforce the goals of our manpower policy through educational enrichment in certain priority areas.

Last year, I authored a 1-year extension of the Nurse Training Act in order to provide for consideration of the reauthorization of the nurse training programs at the same time as all other health professions training programs. The comprehensive bill which I am cosponsoring contains provisions which I believe responsibly address the most pressing national problems with regard to nurses—to wit, improving geographic distribution, minority representation and employment retention—and builds upon the principles established for the other health professions training programs with regard to institutional support for nursing schools and student assistance for nursing students. Although the administration continues to propose major cuts in funds for nurse training programs, I believe firmly that this is the wrong course of action. Severe nursing shortages continue to exist around the country. Because nurses play a critical role in our health care delivery system, I feel that it is imperative at this time to continue our support of nurse training programs.

In closing, Mr. President, I would also like to acknowledge and commend the ranking minority member of the Labor and Human Resources Committee, Senator SCHWEIKER, for the bill he introduced last December dealing with this issue, S. 2144, the Health Professions Educational Assistance and Nurse Training Act of 1980. While I do not agree with all of the provisions of his legislation—particularly those relating to institutional support—I support many of the ideas and policies contained in his legislation and look forward to working with him on the development of a mutually satisfactory piece of legislation.

Mr. President, I request unanimous consent that the text of my bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. [illegible]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Care Management and Health Care Personnel Distribution Improvement Act of 1980".

SEC. 2. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—HEALTH CARE MANAGEMENT

SEC. 101. (a) The Congress finds that—

(1) management plays a crucial role in determining the cost, quality, availability, and accessibility of health care services;

(2) the quality of management in health care facilities does not meet its full potential due in part to the fact that modern management skills are not utilized to the maximum extent feasible, nor are adequate resources provided to assure effective management; and

(3) in order for management to be effective in health care settings, physicians, other health care providers, managers, and administrators must receive appropriate training in management.

(b) It is the purpose of this subpart to encourage effective management of health care services in determining the cost, quality, availability, and accessibility of such services, and to target resources to improve management in health care.

SEC. 102. Section 748(b)(3)(B) is amended by striking out clause (ii) and by redesignating clauses (iii), (iv), and (v) as clauses (ii), (iii), and (iv), respectively.

SEC. 103. Section 749 is amended to read as follows:

"HEALTH CARE MANAGEMENT FELLOWSHIPS

"SEC. 749. (a) The Secretary may make grants to accredited schools of public health, and other public and nonprofit private institutions that offer a program in health administration accredited by a body or bodies approved for such purpose by the Secretary of Education and which meets such other quality standards as the Secretary by regulation may prescribe, to provide fellowships to students enrolled in such program.

"(b)(1) No grant for fellowships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary by regulation may prescribe. Fellowships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary.

"(2) Fellowships awarded under grants made under subsection (a) shall be for a period not to exceed three years, and shall provide for tuition and fees and such stipends and allowances (including travel and subsistence expenses and dependency allowances) in accordance with this section for the fellows as the Secretary may deem necessary.

"(c) No grant for fellowships may be made under this section unless the applicant provides assurances satisfactory to the Secretary that fellowship recipients shall receive at least 2 years of academic training followed by one year of supervised training by the applicant in a hospital-affiliated primary care center under section 328, a migrant health center under section 329, a community health center under section 330, a health maintenance organization under section 1301, or a health systems agency under section 1512 of this Act, or a community mental health center under section 201 of the Community Mental Health Centers Act, or a public or nonprofit private hospital located in an area designated by the Secretary under section 330(b)(3), an official State or local health agency, or a facility owned or operated by the Public Health Service or the Indian Health Service.

"(d) There are authorized to be appropriated for payments under grants under subsection (a), $6,000,000 for the fiscal year ending September 30, 1981, $7,000,000 for the fiscal year ending September 30, 1982, and $8,000,000 for the fiscal year ending September 30, 1983.".

Sec. 104. (a) Section 791(c)(2)(A)(i)(II) is amended by striking out "$100,000" and inserting in lieu thereof "$150,000".

(b) Section 791(c)(2)(A)(ii) is amended—

(1) by striking out "1979" and inserting in lieu thereof "1982"; and

(2) by striking out "1976" and inserting in lieu thereof "1980".

(c) Section 791(c)(2)(A) is amended—

(1) by striking out "and" at the end of clause (ii) (II); and

(2) by redesignating clause (iii) as clause (vi) and by inserting the following new clauses after clause (ii):

"(iii) contains assurances satisfactory to the Secretary that—

"(I) in the fiscal year ending September 30, 1981, at least 7 percent of the entering class is composed of individuals from minority groups and individuals from rural or urban areas designated by the Secretary under section 330(b)(3);

(II) in the fiscal year ending September 20, 1982, at least 10 percent of the entering class is composed of individuals from minority groups and individuals from rural or urban areas designated by the Secretary under section 330(b)(3); and

"(II) in the fiscal year ending September 30, 1983, at least 12 percent of the entering class is composed of individuals from minority groups and individuals from rural or urban areas designated by the Secretary under section 330(b)(3);

"(iv) contains assurances satisfactory to the Secretary that the program for which such application was submitted shall provide, or plans to provide within 12 months, either directly or through agreement with an appropriate entity, academic courses in at least three of the following disciplines:

"(I) finance (particularly as applied to health care),

"(II) marketing (particularly as applied to health care),

"(III) economics (including macro-economics and micro-economics, and with special emphasis on health economics),

"(IV) epidemiology for administration and planning,

"(V) health planning,

"(VI) health policy, law, and regulation, and

"(VII) information systems;

"(v) contains assurances satisfactory to the Secretary that the program for which such application was submitted shall provide a concentration or special emphasis on one or more of the following:

"(I) health planning,

"(II) health policy,

"(III) ambulatory care services,

"(IV) long-term care,

"(V) home health care,

"(VI) multi-unit care systems,

"(VII) comprehensive prepaid service systems,

"(VIII) mental health administration, and

"(IX) any other health care delivery system determined by the Secretary to require special emphasis; and".

(d) Section 791 (d) is amended—

(1) by striking out "and" after "1979"; and

(2) by inserting ", $4,000,000 for the fiscal year ending September 30, 1981, $4,500,000 for the fiscal year ending September 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983" after "1980".

Sec. 105. The heading of section 792 is amended to read as follows:

"SPECIAL PROJECTS FOR SCHOOLS OF PUBLIC HEALTH".

Sec. 106. Subpart I of part G of title VII is amended by adding the following new sections at the end thereof:

"SPECIAL CURRICULA AND FACULTY DEVELOPMENT PROJECTS FOR GRADUATE PROGRAMS IN HEALTH ADMINISTRATION

"Sec. 794. (a) The Secretary may make grants to assist education institutions with accredited programs in health administration to meet the costs of developing curricula designed to improve training in health care management. Such curricula may include—

"(1) finance (particularly as applied to health care);

"(2) marketing (particularly as applied to health care);

"(3) economics (including macro economics and micro-economics, and with special emphasis on health economics);

"(4) epidemiology and health planning;

"(5) health policy, law, and regulation;

"(6) quality assurance and assessment;

"(7) information systems;

"(8) health services organization and management for students in health disciplines other than health administration; and

"(9) management of ambulatory care services.

"(b) For purposes of this section, the term 'accredited program in health administration' means a graduate program accredited for the purpose of training individuals in health administration by a body or bodies approved for such purpose by the Secretary of Education and meets such other standards as the Secretary may be regulation prescribe.

"(c) There are authorized to be appropriated for grants under this section, $3,000,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983.

"FACULTY DEVELOPMENT PROGRAMS

"Sec. 794A. (a) The Secretary may make grants to assist accredited schools of public health and other education institutions with accredited programs in health administration to meet the costs of establishing and operating faculty development programs. Such faculty development program shall—

"(1) train individuals in management or other disciplines that are, in the judgment of the Secretary, underrepresented in programs of health administration and necessary to improve training in health care management; and

"(2) train individuals experienced in such management disciplines with respect to health care issues relating to the teaching of health administration.

"(b) The Secretary may not approve an application for a grant under this section unless such application contains assurances satisfactory to the Secretary that at least three individuals shall complete the program in each year for which an application is made.

"(c) Grant funds awarded under this section shall be used to provide 12 month fellowships to individuals who—

"(1) have received a doctoral degree or equivalent terminal professional recognition in a discipline determined by the Secretary to be underrepresented in programs of health administration and necessary, to improve training in health care management; and

"(2) agree to serve as a faculty member for a period of not less than two years in an accredited school of public health or other educational program with accredited programs in health administration.

"(d) There are authorized to be appropriated for grants under this section $1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983.".

Sec. 107. Part G of title VII is amended by adding the following new subpart at the end there[illegible]

"[illegible]t III—Health Care Management Programs

"TRAINING IN HEALTH CARE MANAGEMENT FOR HEALTH CARE PROFESSIONALS

"Sec. 799. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private education institutions and other appropriate nonprofit private entities (determined by the Secretary to be capable of carrying out grants and contracts under this section) to conduct management training programs for physicians, nurses, other providers of health care, managers and administrators in health care facilities and institutions, official State and local health agencies, and health planning agencies. Grants and contracts under this section may not be used to support training with respect to the financial gain of an individual.

"(b) There are authorized to be appropriated for grants and contracts under this section, $2,000,000 for the fiscal year ending September 30, 1981, $2,000,000 for the fiscal year ending September 30, 1982, and $2,000,000 for the fiscal year ending September 30, 1983.

"REPORT ON HEALTH CARE MANAGEMENT

"Sec. 799A. (a) The Secretary shall enter into a contract with an appropriate public or private entity or entities to conduct an evaluation of health care management and submit a report, including recommendations, to the Secretary. Prior to submission of such report, the Secretary shall make such report available to interested parties and affected Federal agencies for comment. The Secretary shall submit such report in original form, accompanied by comments provided by the Secretary, any interested parties, and any Federal agencies, to the Committees on Labor and Human Resources and Finance of the Senate, and the Committees on Interstate and Foreign Commerce and Ways and Means of the House of Representatives, within 24 months after the date of the enactment of this Act.

"(b) The report submitted pursuant to this section shall contain—

"(1) an analysis of management in health care and a comparison of health care management and management in other major industries;

"(2) an identification and evaluation of management skills utilized in major industries and underutilized in health care with respect to the application of such skills to health care management;

"(3) an assessment of the educational needs of individuals in or entering health care management positions;

"(4) an evaluation of Federal policy with regard to reimbursement of health care services, the application of the antitrust laws, consumer representation and participation, the imposition of limitations on administrative costs, and any other Federal policies that, in the judgment of the Secretary, have an impact on the management of health care facilities or institutions;

"(5) a comparison of incentives to individuals to encourage the pursuit of management careers in health care and management careers in other major industries, and an evaluation of incentives to individuals to encourage careers in various types of facilities;

"(6) an evaluation of the interaction between the health care industry and other industries with regard to management; and

"(7) any other issue specified by the Secretary.

"(c) There are authorized to be appropriated for contracts under this section, $1,000,000 for the fiscal year ending September 30, 1981.".

TITLE II—SPECIAL PROJECTS AND EXPERIMENTS

Subpart A—SPECIAL PROJECTS FOR PHYSICIAN GRADUATE TRAINING TO ENCOURAGE IMPROVED GEOGRAPHIC AND SPECIALTY DISTRIBUTION

SEC. 201. (a) The Congress finds that—

(1) the availability of high quality health care to all Americans is a national goal;

(2) there are many areas in the United States that do not attract adequate numbers and types of health professions personnel to meet the health care needs of such areas;

(3) recent patterns of physician specialization have resulted in inadequate numbers of physicians engaged in the delivery of primary health care and other under represented health care specialties;

(4) the geographic location of residency training programs has a significant relationship to the geographic distribution of physician personnel; and

(5) clinical experiences and other educational programs during the residency training period may influence the specialty, practice, location, and nature of future physician medical practice.

(b) It is the purpose of this title to enhance the physician residency training experience in order to improve the geographic and specialty distribution of physicians.

SEC. 202. (a)(1) The Secretary may make grants to schools of medicine and osteopathy, teaching hospitals, and other appropriate entities with accredited physician residency training programs in internal medicine, pediatrics, family practice, obstetrics and gynecology, and psychiatry, to meet the costs of innovative educational programs for physicians in such residency programs that encourage such physicians to locate their practice in designated medically underserved areas and health manpower shortage areas.

(2) Such educational programs may include—

(A) support for resident preceptorships in medically underserved areas and health manpower shortage areas that are not currently part of the hospitals' regular assignment of residents;

(B) support for faculty stipends to involve practitioners who are practicing in medically underserved areas and health manpower shortage areas and not currently involved in the resident teaching program to serve as preceptors and role models for residents;

(C) appropriate educational activities for residents regarding the unique problems of health care delivery in medically underserved areas, or the cultural characteristics and unique health problems of identified underserved populations in the region served by the institution, or informational and career counseling programs to give residents information regarding practice opportunities in underserved areas.

(3) Grants under this section may not be used for the training of residents currently supported under Federally funded residency training programs in general internal medicine, general pediatrics, and family practice.

(b)(1) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, and public health to assist in meeting the costs to such school of providing projects to—

(A) plan, develop, and operate or maintain a physician residency training program in preventive medicine (including environmental and occupational health); and

(B) support stipends for residents in any such program who plan to specialize or work in preventive medicine (including occupational or environmental health).

(c) The Secretary may make grants to and enter into contracts with schools of medicine and osteopathy, teaching hospitals, and other appropriate entities to assist in meeting the costs of projects to plan, develop, operate or maintain a physician residency training program in physical medicine and rehabilitation and physician residency training programs in other non-primary care specialties designated to be in undersupply by the Secretary.

(d)(1) The Secretary may make grants to schools of medicine, schools of osteopathy, and teaching hospitals with approved residency training programs in internal medicine, pediatrics, family practice, obstetrics/gynecology and psychiatry or federally qualified health maintenance organizations, community health centers or other ambulatory care facilities affiliated with schools of medicine, schools of osteopathy or teaching hospitals with such training programs for the purposes of establishing new residency programs in such specialties based in such ambulatory care facilities or expanding existing residency training programs to significantly increase the amount of training in such ambulatory care facilities.

(2) Grants under this subsection shall be used only to cover the educational costs of such residency training programs.

(3) In awarding grants under this subsection, the Secretary shall give priority to applications to conduct—

(A) programs for training of residents in ambulatory care in medically underserved areas and health manpower shortage areas;

(B) programs that include the interdisciplinary team approach to ambulatory care delivery, particularly such programs that integrate the use of nurse practitioners, physician assistants, and other auxiliary personnel in the delivery of primary care services.

(4) Grants under this subsection may not be used solely for the training of physician residents receiving support under federally funded physician residency programs in general internal medicine, general pediatrics, and family practice.

(e)(1) The Secretary may make grants to schools of medicine and osteopathy, teaching hospitals, and other appropriate entities to meet the educational costs of innovative programs for residents in approved residency training programs that—

(A) prepare residents for teaching medical students and other hospital staff by providing—

(i) programs for training in techniques of teaching, supervision, and consultation, and curriculum development and evaluation methods suited to the clinical setting,

(ii) programs that provide at least one faculty member with experience in and training as a specialist in medical education and curriculum development;

(B) develop, implement, and evaluate educational programs for physician residents in the social and behavioral sciences as such sciences apply to direct patient care in inpatient and outpatient health care settings;

(C) develop, implement and evaluate innovative educational programs for physician residents in the humanities and human values (including medical ethics) as may be applied to direct patient care in inpatient and outpatient health care settings;

(D) develop, implement, and evaluate educational programs to teach physician residents principles of cost containment, organization of health services, and epidemiology as such principles apply to direct patient care in inpatient and outpatient health care settings.

(2) Grants under this subsection may not be used solely for the training of physician residents receiving support under federally funded physician residency training programs in general internal medicine, general pediatrics, and family practice.

(f) Grants under this section to support physician residency training programs shall not be deducted from the net cost of approved educational activities included by a provider of service (as defined in section 1861 (u) of the Social Security Act) as a reasonable cost of such services for purposes of reimbursement under title XVIII of such Act.

(g) There are authorized to be appropriated for grants under this section $4,000,000 for the fiscal year ending September 30, 1981, $5,000,000 for the fiscal year ending September 30, 1982, and $6,000,000 for the fiscal year ending September 30, 1983.

Subpart B—Experiments

SEC. 203. (a) The Secretary shall undertake and support research, evaluation, and demonstration projects (which may include and shall be coordinated with experimental and demonstration projects authorized under the Social Security Act and under section 402 of the Social Security Amendments of 1967, as amended) with respect to changes in Federal health care reimbursement policies. Such projects shall—

(1) encourage—

(A) individuals to enter careers in undersupplied physician specialties and other health professions,

(B) health personnel to practice in health manpower shortage areas (as defined in section 332) or medically underserved areas designated by the Secretary under section 330(b)(3), and

(C) training of graduate physicians in ambulatory health care settings;

(2) determine the effect of different reimbursement rates for the same physician services based on the physician's specialty and the effect that the elimination of such differentials may have on physician specialty choice and the cost of health care;

(3) determine financial incentives necessary to encourage health professionals to practice in health manpower shortage areas or areas designated by the Secretary under section 330(b)(3);

(4) determine the adequacy of reimbursement for non-procedure oriented physician services and the economic impact of current reimbursement policies concerning procedure-oriented services;

(5) assess the effect of direct reimbursement of primary care non-physician providers on the cost and availability of primary care health services in health manpower shortage areas or areas designated by the Secretary under section 330(b)(3) and the cost of such direct reimbursement to the entire health care system;

(6) determine the changes necessary in current reimbursement policies to encourage the graduate training of physicians in ambulatory care settings (including ambulatory care settings in health manpower shortage areas) and the cost of such reimbursement policies to the health care system; and

(7) assess the cost and impact of altering reimbursement policies to include reimbursement for disease prevention and health promotion activities in the primary care setting.

(b) The Secretary shall annually submit interim reports to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and

Means and Interstate and Foreign Commerce of the House of Representatives regarding the progress of projects undertaken in accordance with this section. The Secretary shall submit a final report with legislative and other appropriate recommendations to such committees within three years of the date of the enactment of this Act.

Sec. 204. Section 305 is amended by redesignating subsections (c), (d), and (e) as subsections (d), (e), and (f), respectively, and by inserting the following after subsection (b):

"(c)(1) In carrying out section 304(a), the Secretary, acting through the Center and coordinating with other appropriate agencies, shall conduct and support research, evaluation, and demonstration projects to improve health care management. Projects conducted under this section may be coordinated with experiments and demonstration projects authorized under the Social Security Act and under section 402 of the Social Security Amendments of 1967, as amended.

"(2) Projects conducted under this section may include—

"(A) research, evaluation, and demonstration projects regarding the application of management techniques that are presently underutilized to the health care industry;

"(B) research, evaluation, and demonstration projects regarding alternative health care delivery systems to integrate health care services in the community;

"(C) research, evaluation, and demonstration projects of multi-institutional health care systems and other organizational structures, and the cost, accessibility, and quality of care provided by such systems; and

"(D) other research, evaluation, and demonstration projects that, in the judgment of the Secretary, will improve health care management.".

TITLE III—ALIEN GRADUATES OF FOREIGN MEDICAL SCHOOLS

Sec. 301. (a) Section 212(j)(1)(A) of the Immigration and Nationality Act (8 U.S.C. 1182) is amended by adding at the end thereof the following: ", and shall submit to the Commissioner on Immigration and Naturalization and the Secretary of Health and Human Services—

"(I) an assessment of the staffing requirements of the hospital departments in which the alien will participate or be trained; and

"(II) a staff utilization plan that provides for the optimum utilization of all available health professionals based on the service requirements of such departments.".

(b)(1) Section 212(j)(1)(D) of the Immigration and Nationality Act is amended to read as follows:

"(D) The duration of the alien's participation in the program of graduate medical education or training for which the alien is coming to the United States is limited to the lesser of seven years or the time typically required to complete such program as determined by the Director of the International Communication Agency, or the Director's delegate, at the time of the alien's entry into the United States, based on criteria established by the Secretary of Health and Human Services, however, the alien may, with the approval of the Director, or the Director's delegate, change the designated program of graduate medical education or training, but such change may not be made more than once or later than two years after the alien enters the United States as an exchange visitor or acquires exchange visitor status, provided that the commitment and written assurances under subparagraph (C) of this paragraph have been filed and approved with respect to the alien's new program.".

(2) Section 212(j)(1)(D) of the Immigration and Nationality Act, as amended by this subsection, shall be applicable to any alien entering the United States as an exchange visitor on or after January 10, 1978, or acquiring exchange visitor status on or after such date, for a program under which the alien will receive graduate medical education or training.

(c) Section 212(j)(2)(A) of the Immigration and Nationality Act is amended by striking out "December 31, 1980" and inserting in lieu thereof "December 31, 1985".

Sec. 302. (a) Section 332 of the Public Health Service Act is amended by adding the following new subsection at the end thereof:

"(i)(1) Public and private nonprofit hospitals with accredited residency training programs in which more than 25 percent of the residency positions in any such program are filled by alien graduates of foreign medical schools shall be deemed to be health manpower shortage areas.

"(2) For the purpose of assignment of Corps members under sections 333 and 752 (d), such hospitals shall be considered among facilities with the greatest health manpower shortage. Assignment of Corps members shall, whenever possible, reduce the number of alien graduates of foreign medical schools in residency positions in such facilities.".

(b)(1) Section 334(b) of the Public Health Service Act is amended by inserting the following after paragraph (3):

"(4)(A) In the case of one or more Corps members assigned to a hospital described in section 332 (i), the Secretary shall waive the application of subsection (a)(3) to the extent provided in subparagraph (B). In order for the application of subsection (a)(3) to be waived, the hospital shall demonstrate to the satisfaction of the Secretary that the position available for the Corps member or members, whether in a residency training program pursuant to section 752(b)(5)(A) or as a practitioner pursuant to section 333, is attributable to the termination of one or more positions filled by an alien graduate of a foreign medical school in a residency training program within the previous 12 months.

"(B) If the Secretary determines that the hospital has demonstrated satisfactorily that the position filled by such Corps member or members is attributable to the termination of a position filled by an alien graduate of a foreign medical school as provided in subparagraph (A), the Secretary shall reduce the sum paid to the United States under subsection (a)(3) to the extent that such sum exceeds the sum paid by the hospital to such alien.".

(c)(1) Section 752(a) of the Public Health Service Act is amended by inserting "section 753(d)(2) and" after "Except as provided in".

(2) Section 752(b)(5)(A) of the Public Health Service Act is amended by adding the following before the period at the end thereof: ", except in the case of an individual who chooses to perform such individual's residency as a member of the Corps in a hospital described in section 332(i) as provided in section 753(d)(2).".

(3) Section 753(d) is amended—

(A) by inserting "(1)" after "(d)"; and

(B) by adding the following new paragraph at the end thereof:

"(2) An individual may choose to perform such individual's residency as a member of the Corps in a hospital described in section 332(i), and such residency shall be counted toward satisfying a period of obligated service under this subpart.".

Sec. 303. In order to reduce hospital dependence on alien graduates of foreign medical schools the Secretary of Health and Human Services shall—

(1) identify the States in which there are hospitals that have accredited residency training programs in which alien graduates of foreign medical schools fill more than 25 percent of the residency positions, and identify such hospitals; and

(2) develop a plan, in cooperation with the State and appropriate municipalities, with each State identified under paragraph (1), to reduce dependence on such alien graduates of foreign medical schools through the utilization of all available Federal, State, and local resources.

Sec. 304. The Secretary is authorized to enter into contracts with appropriate consultants to assist a hospital in formulating a staff utilization plan as provided in section 212(j)(1)(A) of the Immigration and Nationality Act.

Mr. JAVITS. Mr. President, I ask unanimous consent to have printed in the Record a statement on the bill by one of its cosponsors, the Senator from Massachusetts (Mr. Kennedy).

The PRESIDING OFFICER. Without objection, it is so ordered.

STATEMENT BY MR. KENNEDY

I am pleased to cosponsor the Health Care Management and Health Care Personnel Distribution Improvement Act of 1980, introduced by my good friend and colleague Senator Javits today. This bill compliments the Health Professions Training and Distribution Act of 1980 which I have introduced and which Senator Javits has cosponsored.

I firmly believe that we must strengthen the management capability within our health care system. The health industry is the third largest industry in the country. How we manage our resources is indeed critical in determining the costs, quality, availability, and accessibility of health services. Our success in being able to achieve cost containment relies strongly on this management capability. Therefore, it is essential for us to strengthen the programs that train our health care managers.

Senator Javits has also appropriately directed our attention to the essential role that physician graduate training plays in determining where our physicians practice, and in what specialties they concentrate their activities. We have encouraged the growth in the number of residencies in family practice, primary care internal medicine, and primary care pediatrics. We have encouraged the growth in psychiatric residency training programs. But we must also be concerned about meeting our needs in other specialties such as physical medicine and rehabilitation, and directing the attention of our residents to meeting the needs of our underserved populations.

I join Senator Javits in recognizing the difficulty that our large, municipal hospitals, which serve many of our most needy populations, have in meeting their requirements for physicians. I believe that we must support domestic programs that will solve this problem. Until these programs are in place, we would consider extension of the provision that permits waiving the 1976 requirements affecting the entry of foreign trained physicians. However, we must regard this as a temporary, time-limited extension. Although I support the thrust of Senator Javits' amendment, I have strong reservations about the extent to which National Health Service Corps scholarship recipients, as interns and residents, should be permitted to discharge their service obligation while in training programs in these hospitals.

I look forward to examining these issues with Senator Javits as the Subcommittee on Health and Scientific Research considers the extension of the health professions educational assistance legislation.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

MAR 6 1980

The Honorable Walter F. Mondale
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

Enclosed for consideration by the Congress is a draft bill "To amend provisions of law concerned with health professions education."

The draft bill would authorize appropriations of $426 million for fiscal year 1981, and "such sums as may be necessary" for fiscal years 1982 and 1983, for various health professions education authorities. A detailed summary of the draft bill is enclosed.

The primary objectives of the draft bill are to --

-- remove incentives for unwarranted growth in the aggregate supply of health professionals, especially physicians.

-- promote an increase in the supply of primary care health professionals, currently in short supply.

-- assure the availability of health professionals in medically underserved areas, largely by strengthening the role of the National Health Service Corps.

-- increase minority participation in the health professions.

-- target Federal resources to promote other national priorities, such as public health training, cost-containment and efficiency in delivery of health care services, and care for high-risk groups, such as the elderly, pregnant women, and children.

The health professions education assistance authorities of the last two decades focused primarily on stimulating increases in the aggregate supply of health care professionals. The nation's training capacity has been significantly expanded as a consequence. Current and projected aggregate supply of health professionals appears to be adequate to meet the requirements of our health care delivery system. However, there is a continued need to address the problems of geographic and specialty maldistribution.

This draft bill would serve as the vehicle to refine our Federal health professions education assistance efforts for promoting a balanced supply of health professionals to meet the health care needs of the American people.

First, termination of capitation grants, and elimination of general construction grants and start-up assistance, would remove incentives for unwarranted growth in the aggregate supply of health professionals. However, short-term financial distress assistance would continue to provide grants to institutions experiencing serious financial difficulties and requiring assistance for achieving fiscal stability and managerial reforms.

Second, continued targeted support for primary care physician training (family medicine, general internal medicine, and general pediatrics), nurse practitioner and physician assistant training, and training in dental team practice would promote increases in the supply of primary care health professionals.

Third, the expansion of the National Health Service Corps Program would increase the availability of much needed health professionals in health manpower shortage areas. The draft bill would also enact an authority for developing cooperative agreements with States to reduce geographic maldistribution of health professionals. In addition, the draft bill would permit continuation of the Health Professions Student Loan Repayment Program, which encourages individuals to practice in a health manpower shortage area in return for partial loan forgiveness. To complement these programs and those in primary care training, the draft bill would continue support for area health education centers, which provide remote site delivery of health care services and primary care training opportunities in underserved areas.

Fourth, continued support for the exceptional financial need scholarships program and the disadvantaged assistance program would promote increased training opportunities and participation of minorities and low-income individuals in the health professions. The disadvantaged assistance program would be targeted administratively to emphasize linkages between recruitment and enrichment programs, aimed at attracting disadvantaged students and increasing their enrollment in the health professions schools.

Fifth, special projects grants would target resources to complement initiatives in promoting a more balanced supply of health professionals, focusing on public health and primary care training, especially for high risk-groups, and promotion of cost-containment and efficiency in the management and delivery of health care services.

Sixth, the draft bill would extend for three more years the phase-in of the special immigration requirements for medical exchange visitors, so as to prevent substantial disruption in the health services provided by specific medical training programs.

We urge that the Congress give the draft bill its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of the draft bill would be in accord with the program of the President.

Sincerely yours,

/s/ Patricia Roberts Harris

Patricia Roberts Harris

Enclosures

A BILL

To amend provisions of law concerned with health professions education.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Short Title and References in Act

Section 1. (a) This act may be cited as the "Health Professions Education Amendments of 1980".

(b) Whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act, unless otherwise specifically stated.

Repeal of Capitation Authorities

Sec. 2. (a)(1) Paragraph (2) of section 770(c) is amended --

(A) in the first sentence, by striking out "For purposes of this section, the" and inserting instead "The", and

(B) in the last sentence, by striking out "and for purposes of section 771, students enrolled in the first of the last four years of such program shall be considered as first-year students".

(2) That paragraph is renumbered as paragraph (11) and is transferred to the end of section 701.

(b)(1) Subsection (b) of section 772 is amended --

(A) by striking out "section 770 or subsection (a) or (b) of section 788" and inserting instead "subsection (b)", and

(B) by inserting "nursing," after "pharmacy,".

(2) That subsection is redesignated as subsection (h) and is transferred to the end of section 788.

(c) Part E of title VII is repealed.

(d) Subpart II of part A of title VIII is repealed.

Repeal of Construction Authorities

Sec. 3. (a) Section 722 is amended to read as follows:

"Payments

"Sec. 722. The Secretary shall reserve, from any appropriation available for a grant for a construction project under this part, the amount of such grant; the amount so reserved may be paid in advance or by way of reimbursement, and in such installments consistent with construction progress, as the Secretary may determine. The Secretary's reservation of any amount under this section may be amended by him, either upon approval of an amendment of the application or upon revision of the estimated cost of construction of the facility."

(b) Section 803 is amended to read as follows:

"Payments

"Sec. 803. The Secretary shall reserve, from any appropriation available for a grant for a construction project under this subpart, the amount of such grant; the amount so reserved may be paid in advance or by way of reimbursement, and in such installments consistent with construction progress, as the Secretary may determine. The Secretary's reservation of any amount under this section may be amended by him, either upon approval of an amendment of the application or upon revision of the estimated cost of construction of the facility."

(c) Section 723 is amended --

(1) by inserting "former" before "section 720(a)(1)" and "section 720(a)(2)",

(2) by striking out "section 722" and inserting instead "former section 722(d)",

(3) in subsection (a)(2), by inserting "(including the lack of further need for the teaching, research, or other capacity)" after "good cause", and

(4) in subsection (b)(2), by inserting "(including the lack of further need for the training capacity)" after "good cause".

(d) Section 804 is amended by inserting "(including the lack of further need for the training capacity)" after "good cause".

(e) Section 724 is amended to read as follows:

"Regulations

"Sec. 724. The Secretary may make such regulations as he finds necessary to carry out the provisions of this part."

(f) Sections 720, 721, 725, 801, and 802, subsections (a), (b), (c), and (f) of section 726, and subsections (a), (b), (c), and (f) of section 805 are repealed.

Repeal of Start-up Assistance Authority

Sec. 4. Section 788(a) is repealed.

Consolidation and Extension of Financial Distress Authorizations

Sec. 5. (a) Paragraphs (1) and (3) of section 788(b) are each amended by inserting "nursing," after "podiatry," each place it occurs.

(b) Section 788(b) is amended by adding at the end the following paragraphs:

"(6) No school may receive a grant or contract under this subsection unless --

"(A) the school has submitted to the Secretary a plan to address the financial and management problems leading to the need for the grant or contract and has agreed to carry out that plan, and

"(B) the Secretary determines that the plan has a reasonable likelihood of success.

"(7) There are authorized to be appropriated to carry out the provisions of this subsection $9,200,000 for fiscal year 1981, and such sums as may be necessary for the two succeeding fiscal years."

(c) Subpart III of part A of title VIII is repealed.

(d) Section 701 is amended by adding at the end the following paragraph:

"(12) The term 'school of nursing' has the meaning assigned by section 853(2)."

Extension of Waiver of Special Requirements for Medical Exchange Visitors to Prevent Substantial Disruption in Health Services

Sec. 6. Section 212(j)(2)(A) of the Immigration and Nationality Act is amended by striking out "1980" and inserting instead "1983".

Extension and Revision of Primary Care Support Provisions

Sec. 7. (a) Section 780 is amended --

(1) by striking out "and" after "1979," and

(2) by inserting "$15,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years," after "1980".

(b) Section 784 is amended to read as follows:

"General Internal Medicine and General Pediatrics

"Sec. 784. (a) The Secretary may make grants to, or enter into contracts with, any public or nonprofit private hospital, school of medicine or osteopathy, or to or with a public or private nonprofit entity (which the Secretary has determined is capable of carrying out such grant or contract) --

"(1) to plan, develop, and operate, or participate in, an approved professional training program (including a continuing education program or an approved residency or internship program) in the field of general internal medicine or general pediatrics for medical and osteopathic students, interns (including interns in internships in osteopathic medicine), residents, or practicing physicians;

"(2) to provide financial assistance (in the form of traineeships and fellowships) to medical and osteopathic students, interns (including interns in internships in osteopathic medicine), residents, or practicing physicians, who are in need thereof, who are participants in any such program, and who, if interns or residents, plan to specialize or work in the practice of general internal medicine or general pediatrics;

"(3) to plan, develop, and operate a program for the training of physicians who plan to teach in general internal medicine or general pediatrics training programs; or

"(4) to provide financial assistance (in the form of traineeships and fellowships) to physicians who are participants in any such program and who plan to teach in a general internal medicine or general pediatrics training program.

"(b) There are authorized to be appropriated for grants and contracts under this section $22,235,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years."

(c)(1) Section 786(a) is amended --

(A) in paragraph (2), (i) by striking out "practicing physicians, or other medical personnel" and inserting instead "or practicing physicians", and

(ii) by inserting ", if interns or residents," after "and who", and

(B) in paragraph (3), by striking out "and" after the semicolon and inserting instead "or".

(2) Subsections (b) and (c) of section 786 are repealed.

(3) Section 786(d) is amended --

(A) by striking out "to make grants" and inserting instead "for grants and contracts",

(B) by striking out "and" after "1979,", and

(C) by inserting ", $46,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(4) The heading to section 786 is amended by striking out "and General Practice of Dentistry".

Extension and Revision of Nurse Practitioner and Physician Assistant Authorities

Sec. 8. (a) Section 822 is amended to read as follows:

"Nurse Practitioner Programs

"Sec. 822. (a) The Secretary may make grants to and enter into contracts with public or private schools of nursing, medicine, or public health, public or nonprofit private hospitals, and other public or nonprofit entities to establish and operate traineeship programs to train nurse practitioners which give special consideration to individuals who are residents of a health manpower shortage area (designated under section 322).

"(b) No grant or contract may be made under subsection (a) unless the application therefor contains or is supported by assurances satisfactory to the Secretary that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted, in positions for which they have been trained.

"(c)(1) A traineeship funded under this section shall not be awarded unless the recipient enters into a commitment, as prescribed by the Secretary, to practice as a nurse practitioner in a health manpower shortage area (designated under section 332).

"(2) If an individual breaches his commitment under paragraph (1) by failing (for any reason) either to begin such individual's commitment or to complete such commitment, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A=3\phi\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'ϕ' is the sum of the amounts paid under this subsection to or on behalf of the individual and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the private consumer rates of interest, as determined by the Secretary of the Treasury; 't' is the total number of months in the individual's commitment period; and 's' is the number of months of such period served by him. Any amount of damages which the United States is entitled to recover under this paragraph shall, within the one year period beginning on the date of the breach of the commitment, be paid to the United States.

"(3)(A) Any obligation of an individual under this subsection for service or payment of damages shall be canceled upon the death of the individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation of service or payment by an individual under this subsection whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(C) Any obligation of an individual under this subsection for payment of damages may be released by a discharge in bankruptcy under title II of the United States Code only if such discharge is granted after the expiration of the five-year period beginning on the first date that payment of such damages is required.

"(d) The costs for which a grant or contract under this section may be made include costs of preparing faculty members to teach in programs for the training of nurse practitioners.

"(e) For payments under grants and contracts under this section there are authorized to be appropriated $18,000,00 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years."

(b) Section 782 is amended to read as follows:

"Physician Assistant Programs

"Sec. 782. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of medicine or osteopathy and other public or nonprofit private entities to establish and operate traineeship programs to train physician assistants which give special consideration to individuals who are residents of a health manpower shortage area (designated under section 332).

"(b) No grant or contract may be made under subsection (a) unless the application therefor contains or is supported by assurances satisfactory to the Secretary that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted, in positions for which they have been trained.

"(c)(1) A traineeship funded under this section shall not be awarded unless the recipient enters into a commitment, as prescribed by the Secretary, to practice as a physician assistant in a health manpower shortage area (designated under section 332).

"(2) If an individual breaches his commitment under paragraph (2) by failing (for any reason) either to begin such individual's commitment or to complete such commitment, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A=3\phi\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'ϕ' is the sum of the amounts paid under this subsection to or on behalf of the individual and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the private consumer rates of interest, as determined by the Secretary of the Treasury; 't' is the total number of months in the individual's commitment period; and 's' is the number of months of such period served by him. Any amount of damages which the United States is entitled to recover under this paragraph shall, within the one year period beginning on the date of the breach of the commitment, be paid to the United States.

"(3)(A) Any obligation of an individual under this subsection for service or payment of damages shall be canceled upon the death of the individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation of service or payment by an individual under this subsection whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(C) Any obligation of an individual under this subsection for payment of damages may be released by a discharge in bankruptcy under title II of the United States Code only if such discharge is granted after the expiration of the five-year period beginning on the first date that payment of such damages is required.

"(d) The costs for which a grant or contract under this section may be made include costs of preparing faculty members to teach in programs for the training of physician assistants.

"(e) For payments under grants and contracts under this section there are authorized to be appropriated $7,500,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years."

Extension of Authorizations for Dental Team Practice Programs

Sec. 9. (a) Section 783(a) is amended to read as follows:

"Sec. 783. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of dentistry and other public or nonprofit private entities to meet the costs of projects to plan, develop, and operate or maintain a program to train dental students in the organization and management of multiple auxiliary dental team practice in accordance with regulations of the Secretary."

(b) Subsections (c) and (d) of section 783 are repealed.

(c) Section 783(e) is amended --

(1) by striking out "and" after "1979,", and

(2) by inserting ", $2,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(d) The heading to section 783 is amended by striking out "Physician Assistants, Expanded Function Dental Auxiliaries and".

Revision and Extension of the National Health Service Corps and National Health Service Corps Scholarship Program Authorities

Sec. 10. (a) Section 756 is amended --

(1) by striking out subsection (b), and

(2) by striking out the subsection designation "(a)".

(b) Section 753(a) is amended --

(1) in the matter preceding paragraph (1), by inserting "(and may release an individual from all or part of his service obligation under former section 225)" after "section 752(a)",

(2) in paragraph (2), by striking out (A) the clause designation "(A)", and (B) everything after "section 333(c)," but before the period, and

(3) by striking out the second sentence.

(c) Section 755(a)(1) is amended by striking out "his period of obligated service" and inserting instead "a period of at least two years service".

(d) Section 751(d) is amended to read as follows:

"(d) In determining which applications under the Scholarship Program to approve (and which contracts to accept), the Secretary shall give priority to applications made (and contracts submitted) by individuals who have previously received scholarships under the Scholarship Program or under section 758."

(e) Section 331(f) is amended by striking out "Sections 214 and 216" and inserting instead "Section 214".

(f) Subpart IV of part C of title VII is amended by adding at the end the following section:

"Cooperative Agreements with States

"Sec. 757A. The Secretary may enter into cooperative agreements with States under which --

"(1) a State shall develop a plan for reducing geographic maldistribution of health professionals in the State, utilizing a State health professionals placement program as well as the Corps, and

"(2) the Secretary, upon approval of the plan, shall arrange for appropriate assignment of Corps personnel to the State consistent with the plan and with available Federal resources.

The Secretary shall give priority under this section to States that provide substantial State financial support for health professionals placement programs designed to reduce geographic maldistribution."

(g)(1) The first sentence of section 756 is amended --

(A) by striking out "and" after "1979,", and

(B) by inserting ", $93,500,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(2) The second sentence of that section is amended by striking out "1981" and "1980" and inserting instead "1984" and "1983", respectively.

(h) Section 338 is amended --

(1) by striking out "and" after "1979;", and

(2) by inserting "; $132,696,000 for the fiscal year ending September 30, 1981; and such sums as may be necessary for the two succeeding fiscal years" after "1980".

Extension of Area Health Education Centers Authorizations

Sec. 11. Section 781(g) is amended --

(1) by striking out "and" after "1979,", and

(2) by adding ", $21,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

Extension of Authorizations for the Scholarship and Educational Assistance Programs for the Disadvantaged

Sec. 12. (a)(1) Section 758(c) is amended to read as follows:

"(c) The Secretary shall give special consideration in making grants under this section to schools of medicine, osteopathy, and dentistry."

(2) Section 758(d) is amended --

(A) by striking out "and" after "1979,", and

(B) by inserting ", $10,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(b)(1) Section 787(a)(1) is amended --

(A) by striking out "and enter into contracts with",

(B) by inserting ", and may enter into contracts with public and private entities," after "educational entities", and

(C) by adding at the end "The Secretary may provide funding under this section for stipends."

(2) Section 787(b) is amended --

(A) by striking out "and" after "1979,", and

(B) by inserting "$22,392,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980,".

Revision and Extension of Special Projects Authorities

Sec. 13. (a)(1) Section 788(d) is amended --

(A) by striking out "and enter into contracts with", and

(B) by inserting ", and may enter into contracts with any public or private entity," after "nonprofit private entity".

(2) Section 788(d) is further amended by striking out "such as" and all that follows and inserting instead the following: "(including, but not limited to, projects for public health and health administration training). An applicant for a grant or contract under this subsection shall demonstrate, where appropriate, that the project will be integrated into the core curriculum of the applicant's training program, and shall agree to provide a timetable and criteria for evaluating the success of the project in terms of meeting defined objectives. The Secretary may provide funding under this subsection for stipends."

(3) Section 788(e) is amended to read as follows:

"(e) There are authorized to be appropriated to carry out the provisions of subsection (d) $17,000,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years."

(b)(1) Section 820(a) is amended by striking out paragraphs (1) through (8) and inserting instead the following:

"(1) improve the geographic distribution of nurses, with a focus on areas with low income populations,

"(2) increase nursing education opportunities for individuals from disadvantaged backgrounds,

"(3) develop innovative nursing methods emphasizing primary care and prevention to help meet the needs of high risk groups, especially the elderly, children, and pregnant women, "(4) provide training (such as continuing education and advanced nurse training) to enhance clinical skills, with an emphasis on primary care and the needs of high risk groups, or

"(5) carry out other activities related to nurse training.

An applicant for a grant or contract under this section shall demonstrate, where appropriate, that the project will be integrated into the core curriculum of the applicant's teaching program, and shall agree to provide a timetable and criteria for evaluating the success of the project in terms of meeting defined objectives. The Secretary may provide funding under this section for stipends."

(2) Section 820(d) is amended --

(A) by striking out "and" after "1978,", and

(B) by inserting ", $9,600,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

Abolition of the National Advisory Council on Nurse Training

Sec. 14. (a) Section 851 is repealed.

(b)(1) The first sentence of section 702(a) is amended --

(A) by striking out "parts B, C, D, E, F, and G of", and

(B) by inserting "and title VIII" before the period.

(2) The second sentence of section 702(a) is amended --

(A) by inserting "or title VIII" after "this title", and

(B) by striking out "and public health, and entities which may receive a grant under section 791" and inserting instead "nursing, and public health".

(3) Subsections (b) and (c) of section 702 are each amended by striking out "(other than subpart II of part G thereof)" and inserting instead "and title VIII".

Elimination of Unnecessary Reporting Requirements

Sec. 15. Section 951 of the Nurse Training Act of 1975, and sections 336 and 751(i) are repealed.

Amendments to Health Education Assistance and Nursing Student Loans Provisions

Sec. 16. (a) The heading to subpart I of part C of title VII is amended to read as follows:

"Subpart I -- Health Education Assistance Loans"

(b)(1) The second sentence of section 728(a) is amended --

(A) by striking out "Thereafter" and inserting instead "After September 30, 1983", and

(B) by striking out "September 30, 1982" and inserting instead "September 30, 1985".

(2) Section 728(a) is amended by adding at the end the following sentence: "Commitments to insure loans under this subpart are authorized for any fiscal year only to the extent or in such amounts as are provided in an appropriation Act."

(c) Section 729(a) is amended --

(1) in the first sentence, by striking out everything after "$10,000" through "school of pharmacy", and

(2) in the second sentence, by striking out everything after "$50,000" through "school of pharmacy".

(d)(1) The first sentence of section 701(11) is amended by inserting ", or to a degree, diploma, or equivalent in nursing" before the period.

(2) Section 737(1) is amended by inserting "nursing," after "veterinary medicine,".

(e) Section 731(a)(1)(A) is amended --

(1) by adding "and" at the end of clause (iv),

(2) by striking out clause (v), and

(3) by renumbering clause (vi) as (v).

(f) Subparagraphs (B) and (C)(ii) of section 731(a)(2) are each amended by striking out "accredited" and inserting instead "approved".

(g) Section 731(a)(2)(B) is amended by striking out "(ii) that the period of the loan may not exceed 23 years from the date of execution of the note or written agreement evidencing it, and (iii)" and inserting instead "and (ii)".

(h)(1) Section 731(b) is repealed.

(2) Section 731(a)(2)(D) is amended by striking out "(within the limits set forth in subsection (b))".

(i) Section 731 is amended by adding at the end the following subsection:

"([illegible]) The Secretary may not insure under the provisions of this subpart a loan made to an individual who is in default on a loan made under this subpart or under part B of title IV of the Higher Education Act of 1965."

(j) Section 835(b)(4) is amended by striking out ", and that while the agreement remains in effect no such student who has attended such school before October 1, 1980, shall receive a loan from a loan fund established under section 204 of the National Defense Education Act of 1958".

Modifications to Health Professions Data Provisions

Sec. 17. (a) Section 708(b) is amended by striking out paragraphs (1) and (3) and the paragraph designation "(2)".

(b) Section 708(f) is repealed.

Repeal of Obsolete and Unneeded Provisions

Sec. 18. Section 700, subpart III of part C of title VII, section 759, part D of title VII, section 785, subsections (c), (f), and (g) of section 788, section 789, part G of title VII, section 821, subpart I of part B of title VIII, section 841, and subpart III of part B of title VIII are repealed.

Technical and Conforming Amendments

Sec. 19. (a) Section 331(g) is repealed.

(b)(1) Section 701 is amended --

(A) in paragraph (3), by striking out "which meets the eligibility conditions set forth in section 721(b)(1)",

(B) by striking out paragraphs (5), (7), and (9), and

(C) in paragraph (10), by striking out ", Education, and Welfare" and inserting instead "and Human Services".

(2) Section (2)(f) is amended by striking out "701(9),".

(c) Section 703 is amended --

(1) by striking out subsection (b), and

(2) by striking out the subsection designation "(a)".

(d) The first sentence of section 704 is amended by inserting "nursing," after "podiatry,".

(e) Section 708(c) is amended --

(1) by striking out the first sentence, and

(2) by striking out "additional" in the second sentence.

(f) Section 710 is amended by striking out "except for grants under section 770".

(g) Section 731(a)(1)(A)(ii) is amended by striking out "(as defined in section 770([illegible])(2))".

(h) Section 735(c)(1) is amended by striking out "clauses (A) and (B) of".

(i) The first sentence of sections 735(c)(2) and 754(c) are each amended --

(1) by striking out "maximum legal prevailing rate" and inserting instead "private consumer rates of interest", and

(2) by striking out "Treasurer of the United States" and inserting instead "Secretary of the Treasury".

(j) Section 737(1) is amended by striking out everything after "United States" and inserting instead a period.

(k) The heading to section 788 is amended to read as follows:

"Project Grant Authority for Financial Distress and Special Projects"

(ℓ) Subsections (b) and (c) of section 820 and section 856(1) are each amended by striking out "Nurse Training" and inserting instead "Health Professions Education".

(m) Section 853 is amended by striking out paragraph (1).

Effective Dates

Sec. 19. (a) The amendments enacted by section 16 of this Act are effective with respect to loans made after the date of enactment of this Act.

(b) The amendments enacted by this Act (other than by section 16) are effective as of the date of enactment of this Act, except that they shall not apply with respect to funds appropriated for any fiscal year before fiscal year 1981.

Senator Metzenbaum. The Chair wishes to point out to the witnesses today that there are 9 or 10 of them, and under the constraints of time we are going to make it necessary for the Chair to limit the presentations of each of the witnesses.

We will allow the first witness to present the administration's point of view in 10 minutes, and we will ask each of the other witnesses to present their views in 5 minutes so that there may be an adequate amount of time for those of us who are sitting at the committee level to ask some questions, and still bring the hearing to a conclusion by 12 o'clock.

The first witness is Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare.

STATEMENT OF KAREN DAVIS, PH. D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. HENRY FOLEY, ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DHHS; AND DR. EDWARD MARTIN, DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES, HEALTH SERVICES ADMINISTRATION, DHHS

Dr. Davis. Thank you, Mr. Chairman. I am pleased to have with me today Dr. Henry Foley, Administrator of the Health Resources Administration, and Dr. Edward Martin, Director of the Bureau of Community Health Services.

I have a somewhat longer statement I will be happy to submit for the record.

Senator Metzenbaum. All of the statements will be included in the record in total.

Dr. Davis. As you know, the administration's legislation proposal, the Health Professions Education Amendments of 1980, has been submitted for your consideration. This legislation is targeted to provide support for training the types and numbers of professionals necessary to meet the Nation's most serious and pressing health service needs.

This legislation represents our best thinking in this area. However, I want to emphasize our interest in continuing to review carefully other proposals developed by members of this subcommittee and our willingness to work with you in shaping this important legislation.

During the sixties, the Federal government concentrated heavily on helping to increase the supply of health professionals. Today, our best estimates indicate that the supply of most health professionals, especially physicians, is expected to exceed need by 1990. The Health Professions Educational Assistance Act of 1976 marked a change in focus from the previous emphasis on expanded aggregate supply. It placed more emphasis on improving the geographic distribution of health personnel, increasing the supply of individuals trained to provide primary care, and helping students from disadvantaged backgrounds gain access to health professions careers. Yet, despite some recent gains, many problems persist.

First, the maldistribution of health professionals, especially physicians, remains our most pressing concern. Despite increases in overall supply, many areas—largely inner city and rural communities—still lack adequate health personnel. We estimate that in 1990, up to 16,400 additional physicians and midlevel professionals could still be needed in medically underserved areas and facilities. While there has been some growth in the number of physicians entering rural areas, this growth has not affected the most rural and the poorest of our counties.

Between 1971 and 1977, the physician population ratio increased from 48 physicians per 100,000 to 50 physicians per 100,000 in highly rural areas. This compares with an increase in the ratio from 146 physicians per 100,000 in urban areas in 1971 to 168 per 100,000 in 1977. Similarly, in high poverty areas, there has been little change in the physician population ratio. In the poorest counties, the physician population ratio increased from 68 per 100,000 in 1971 to 74 per 100,000 in 1977.

The second problem that persists is that we do not have enough physicians and other health professionals specializing in primary care. In 1950, primary care physicians represented about half of all doctors. By 1975, the percentage of primary care doctors had dropped to 38 percent. It is encouraging that we are beginning to reverse this trend with the aid for training primary care physicians and mid-level practitioners. However, the Institute of Medicine has recommended that at least half of all physicians be in primary care and that 60 to 70 percent of all residency positions be in primary fields to achieve this goal. We are not near the latter figure.

Third, disadvantaged and minority individuals continue to be underrepresented in the health professions. Blacks, Hispanics, and Native Americans comprise 18 percent of the population but only 7 percent of physicians. First-year enrollment of these three groups in medical schools has remained at about 9 percent in the past 4 years. Also, individuals from low-income families continue to be underrepresented in health professions schools.

The administration's proposal targets support on addressing these issues as well as eliminating programs that are no longer necessary.

The administration proposes to terminate capitation grants and start-up assistance and eliminate grants for the construction of teaching facilities. To increase the supply of primary care professionals, the administration would continue targeted support for primary care physician training--that is, training in family medicine, general internal medicine, and general pediatrics, and for the training of nurse practitioners and physician assistants. To help assure that health professionals are available in underserved areas, the administration proposes to stabilize the number of National Health Service Corps scholarships. This policy, together with continued recruitment, will produce a field strength of roughly 9,000, including physicians, dentists and other practitioners by 1990. It will enable us to meet a sizable portion of the estimated need and also provide the flexibility to respond to possible changes in private location and practice patterns.

Finally, the administration proposes to strengthen current programs specifically designed to assist disadvantaged individuals in entering the health professions. We would maintain the exceptional financial needs scholarship program to aid very needy students and would continue the disadvantaged assistance program to recruit disadvantaged and minority students.

In summary, Mr. Chairman, through these programs, the Department can provide leadership, develop national priorities, and assume responsibility for helping to improve the distribution and quality of health professionals.

I would be happy to answer questions, and all of us are looking forward to working with you in developing a viable health policy. Thank you.

[The prepared statement of Dr. Davis follows:]

FOR RELEASE ONLY ON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

KAREN DAVIS, PH.D.

DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

MARCH 10, 1980

Mr. Chairman, and members of the Subcommittee, I am pleased to be here today to discuss health professions education assistance. This Subcommittee has shown strong leadership in developing strategies to meet the nations health personnel needs. The expiration of the Health Professions Education Assistance Act of 1976 and the Nurse Training Amendments of 1979 presents an opportunity to focus and strengthen our efforts to meet requirements for health professionals in the coming decades.

As you know, the Administration's legislative proposal, the Health Professions Education Amendments of 1980, has been submitted for your consideration. This legislation is targeted to provide support for training the types and numbers of professionals necessary to meet the nation's most serious and pressing health service needs.

Our proposal concentrates on alleviating the problems of geographic maldistribution through service-commitment scholarships. It concentrates on addressing the shortage of primary care personnel through support of primary care training programs.

I would also like to point out that our proposal is part of a broader strategy to be complemented by other Administration initiatives such as reimbursement reforms and expanded primary care delivery programs.

This legislation represents our best thinking in this area. However, I want to emphasize our interest in continuing to review carefully other proposals developed by members of this Subcommittee, and our willingness to work with you in shaping this important legislation.

Past Achievements

During the 1960s, the Federal government concentrated heavily on helping to increase the supply of health professionals. This record is impressive in both the level of Federal support and in responsiveness to the nation's health professions schools.

In fact, since 1963, the Federal government has provided nearly $1.5 billion to health professions and nursing schools in construction and start-up assistance alone. Another $1.5 billion has been devoted to capitation grants since 1972.

These programs have had a definite impact on increasing the aggregate supply of health professionals. For example, the supply of active physicians increased from 251,900 in 1960 to 447,800 in 1980: the physician population ratio jumped from 143.6 physicians per 100,000 population to 192.6 physicians per 100,000 people during this period. The supply of full-time registered nurses increased from 504,000 in 1960 to 1,100,000 in 1979.

Our best estimates indicate that the projected supply of most health professionals, especially physicians, is expected to exceed need by 1990.

- Estimates of need for physicians in 1990 range from 444,000 to 574,000 or 181 to 239 physicians per 100,000 population. With a projected supply of 598,000 physicians, there would be an excess of 24,000 to 154,000 physicians.

- For 1985, given current health financing policies and utilization trends, we estimate that the projected supply of registered nurses will be in balance with requirements.

o In 1990, the supply of dentists, pharmacists and veterinarians is expected to exceed requirements.

Problems

The success of these past efforts has brought us to an important watershed in the history of Federal support for health professions training. The Health Professions Educational Assistance Act of 1976 marked a change in focus: it directed our attention toward addressing the problems of distribution rather than increasing the aggregate supply of health professionals.

This legislation placed more emphasis on improving the geographic distribution of health personnel, increasing the supply of individuals trained to provide primary care and helping students from disadvantaged backgrounds gain access to health professions careers.

Yet despite some gains, many problems persist. Our proposal would target resources on addressing these issues, as well as on eliminating programs that are no longer necessary.

Briefly, I would like to review the basic objectives of our proposal.

First, the maldistribution of health professionals, especially physicians, remains our most pressing concern. Despite recent gains in overall supply, many areas -- largely inner city and rural communities -- still lack adequate health personnel. We estimate that in 1990, up to 16,400 additional physicians and mid-level professionals could be needed in medically underserved areas and facilities: 7500 in rural areas; 5200 in inner cities; and 3700 in prisons and mental institutions. These estimates assume that the number of physicians choosing to locate in rural areas increases because more are entering practice in the aggregate. Fortunately, there is evidence of some increase in the number of physicians moving into smaller cities and towns over the past five to seven years. However, most of the increase in physician/population ratios has occurred in medium sized rural towns. Few of these physicians have chosen to locate in underserved areas -- largely poor or highly rural communities with few health resources -- designated as high priority by the Federal government.

-- Between 1971 and 1977, the physician/population ratio increased from 48 physicians per 100,000 to 50 physicians per 100,000 in highly rural areas. This compares with an increase in the ratio from 72 physicians per 100,000 to 87 per 100,000 population in other rural areas -- and an increase in the ratio from 146 physicians per 100,000 to 168 in metropolitan areas.

In high poverty areas, the physician/population ratio increased from 68 physicians per 100,000 to 74 physicians per 100,000 population.

-- In poor rural and urban counties, the problem is exacerbated because many physicians chose not to accept Medicaid patients; 22 percent of primary care physicians have no Medicaid patients.

There is also some expectation that the proportion, as well as the numbers, of physicians going to underserved areas will increase as the supply of doctors grows. Almost 16,000 new physicians are added to the pool each year.

However, aggregate physician to population ratios have increased nearly twice as fast in the 1970's (2.7 percent annually) as in the 1960's (1.5 percent annually), and, as I have indicated, highly rural and poor areas have shown very small increases to date.

Although very rural and poor counties have not benefited from the increased diffusion of physicians as yet, we plan to monitor carefully future patterns as the supply of doctors grows. This is a major reason why the Administration has proposed to stablize the number of NHSC scholarships at the 1981 level. We intend to study the location trends that emerge over the next few years and reappraise our strategies for meeting the needs of underserved areas based on this experience.

It is important to remember that increased supply of health professionals and improved financing of health care services cannot alone attract providers to underserved rural and inner city areas. While we find this prospect hopeful, we know that the multiple problems found in these areas -- professional isolation, the lack of cultural and educational opportunities -- are likely to affect location choices as much as potential income.

Secondly, we do not have enough physicians and other health professionals specializing in primary care. Until recently, the emphasis on technology-oriented medicine led to a decline in the number of primary care providers. In 1950, primary care physicians represented about half of all doctors; by 1975 the percentage of primary care doctors had dropped to 38 percent. It is encouraging that we are beginning to reverse this trend with aid for training primary care physicians (family medicine and general internists and pediatricians) and mid-level practitioners (nurse practitioners and physician assistants).

The Institute of Medicine (IOM) has recommended that primary care physicians constitute at least 50 percent of the physician supply. To achieve this goal, IOM recommends that from 60 to 70 percent of all residency positions be in the primary care fields. These projections stem in part from the Institute's conclusions that primary care practitioners are the most appropriate providers for managing 90 percent of all health problems presented to physicians.

Some studies have shown that specialists spend substantial amounts of their time -- up to 40 percent --providing primary care services. Although this may increase access to basic medical care for some, we believe this suggests overspecialization -- an imbalance between the supply of generalists trained to delivery primary care and the supply of specialists.

Whether specialists are the most appropriate or cost-effective providers of primary care is also often to question.

- Basic primary care delivered by specialists is more expensive than that provided by generalists: internists charge 50 percent more than generalists for a periodic examination and for a follow-up office visit.

- Generalists are specially trained to treat the "whole patient"; specialists training is more hospital oriented and relies more heavily on high technology.

Third, disadvantaged and minority individuals continue to be underrepresented in the health professions. Blacks, Hispanics and Native Americans comprise 18 percent of the population but only 7 percent of physicians. First year minority enrollment in medical schools has remained at about 9 percent for the past four years Also, individuals from low-income families continue to be underrepresented in health professions schools.

The problems of students from disadvantaged backgrounds in entering the health professions are two-fold. One is financial access. Disadvantaged students are likely to have greater difficulty in securing educational loans than students from more advantaged families. Another obstacle is inadequate preparation for professional training. This affects entry into health professions schools as well as retention.

Administration Proposal

As I noted earlier, our proposal targets Federal support for health professions training on programs to address geographic maldistribution and the shortage of primary care practitioners. Capitation grants and construction and start-up assistance programs have played a key role in increasing enrollments in health professions schools. But a substantial increase in the general supply of health professionals -- resulting in a potential oversupply among some personnel -- has eliminated the need for such incentives. For this reason, the Administration proposes to terminate capitation grants and start-up assistance, and eliminate grants for the construction of teaching facilities.

Our proposal would provide short term financial distress assistance to needy institutions including those with high proportions of minority students. These grants would be available to promote fiscal stability and to make management improvements.

To increase the supply of primary care professionals, the Administration would continue targeted support for primary care physician training -- that is, training in family medicine, general internal medicine, and general pediatrics. In addition, special project aid also would be provided for the training of nurse practitioners and physician assistants with a new emphasis on service commitment traineeships rather than institutional support.

To help assure that health professionals are available in underserved areas, the Administration proposes to continue the National Health Service Corps. We plan to maintain the proposed 1981 scholarship levels which will lead to an expansion in NHSC field strength. This will result in the placement of a total of roughly 9000 assignees including physicians, nurse practitioners, physicians assistants, dentists, registered nurses and others by 1990. These plans assume 6700 service committed practitioners and the 1981 level of 2300 volunteers.

I think it is important to remember that these numbers are not simply abstract statistics. They represent physicians, dentists, and other health professionals actually providing high quality health care to people in need. This program directly affects the well being of millions of people -- people not only lack access to health care, but who may also often be poor, members of minority groups, and living in multi-problem areas. One cannot understand the Corps, its mission, or its problems, without an appreciation of this human element.

Some States have supported their own student assistance programs to improve the distribution of health professionals. We favor authorizing the Secretary to enter into cooperative agreements with those States to provide for closer accord in the placement of Corps personnel in Federally designated shortage areas. Such joint Federal-State demonstrations should increase State input in health planning and management, minimize unwarranted duplication of effort, and target all programs toward improving the supply of health professionals in shortage areas.

To provide health professionals for those shortage areas that would not be staffed with Corps personnel, we would extend several other authorities. Our proposal would permit us to continue to repay student loans of individuals who agree to serve in health underserved areas.

Another key program for meeting the needs of health manpower shortage areas is the Area Health Education Center (AHEC) program. This program provides for the enhancement of health professions training opportunities in areas remote from existing education centers. The 21 AHEC programs receiving Federal support in fiscal year 1979 were operating or developing 30 regional centers serving over 433 counties in 22 States.

The Administration proposes to strengthen current programs specifically designed to assist disadvantaged individuals in entering the health professions. We would maintain the Exceptional Financial Need (EFN) Scholarship program to provide very needy students with an obligation free scholarship for one year. This is to encourage the entry of very poor students who may be hesitant to assume a heavy financial obligation or who are unable to obtain loans at such an early stage in their health professions training.

We also plan to continue the Disadvantaged Assistance Program. Under this program, grants are provided to community groups, secondary, undergraduate and health professions schools to recruit disadvantaged and minority students. Disadvantaged assistance grants are also used to support science and health related courses, tutorial services and other forms of educational assistance to promote the acceptance and retention of minority and low-income students in health professions schools.

In an effort to raise the quality and improve the utilization of health professionals, the Federal Government has provided considerable aid for projects in areas of special concern. Current projects to support public health and health administration training are examples. We feel a need to continue special project grant and contract authorities to promote national priorities and initiatives relating to the health professions.

I would like to add that given the projected adequacy of the aggregate supply of physicians in the United States, the Administration favors continuing restrictions on the entry of foreign medical graduates (FMGs). Also, concerns about the quality of FMG training support a restrictive immigration policy. However, we recognize that some hospitals, heavily dependent upon FMGs, may require additional time to adjust to the limitation on FMGs imposed by the Health Professions Educational Assistance Act of 1976, and thus we will also continue waivers for areas where limits on FMGs would cause substantial disruption.

Summary

Mr. Chairman, we recognize that other Federal agencies, educational institutions, the professions and State and local governments among others, will continue to share responsibility for training health professionals. We consider our proposal the nucleus of Federal activity in support of health professions education. Through these programs, the Department can provide leadership, develop national priorities and assume responsibility for helping to improve the distribution and quality of health professionals.

Thank you

Senator **Metzenbaum**. Thank you very much.

Dr. Davis, in January, the President requested a rescission of $98 million for fiscal year 1980 for health professions education programs.

In light of current economic developments, my understanding is that the Department has recommended to OMB an additional recision of $80.7 million for fiscal year 1980, is that correct?

Dr. **Davis**. The administration is still considering possible changes in the budget in light of current economic conditions. However, we do not at this time have any recommendations to make to the Congress.

Senator **Metzenbaum**. My question is, Has the Department made that recommendation to the OMB?

Dr. **Davis**. The recommendations are going back and forth. No final recommendation by the Department has been made.

We have responded to requests by the Office of Management and Budget for possible cuts but these are not our recommendations.

Senator **Metzenbaum**. We have a report here from the Health Administration balanced proposed budget, recommending an additional $80,635,000.

Now, did you or did you not make that recommendation?

Dr. **Davis**. As I indicated, the Department has responded to requests by the Office of Management and Budget for areas where cuts could be made if necessary. These are not necessarily recommendations nor has any final position of the Administration been made.

Senator **Metzenbaum**. Well, I am really having a little difficulty in following you.

You have been asked to make recommendations. There is a documented piece here from the Health Resources Administration that talks about $80 billion additional cut. Now, I understand they are going back and forth, but did you or did you not make a recommendation or an indication that you could make an additional $80 million cut?

Dr. **Davis**. I think part of our difficulty is with the word "recommendation."

Senator **Metzenbaum**. What did you do?

Dr. **Davis**. These are internal discussions within the administration. We are trying to respond to the Office of Management and Budget's request asking where cuts could be made. That is not necessarily a recommendation by the Secretary that the cuts be made.

Senator **Metzenbaum**. What is your prediction of the impact of these cuts on the program if they are made?

Dr. **Davis**. You would have to be more specific about the kinds of cuts you have in mind.

Senator **Metzenbaum**. The kinds that you have in mind, the $80 million. These are your figures, $24 million in advanced nurse training capitation, $9 million in scholarships, $1 million in traineeships, $4,000,035 in medical assistance.

I guess there is something on the previous page. Yes, a whole list of them.

What kind of impact would that have on the program?

Dr. **Davis**. As I have indicated, the Department is standing by its 1980 budget. That budget did request rescissions in the capitation area. The President's budget in 1981 does not include funding in a number of the areas you have just mentioned. Perhaps consistent with that policy would be not requesting funds or requesting rescissions in some of those in the 1980 budget as well.

You cited the ones where we have not included funding in the 1981 President's budget. The determination was made at the time the President's 1981 budget was submitted that those are not high priority areas.

Senator **Metzenbaum**. That they are not high priority?

Dr. **Davis**. That is right.

Senator **Metzenbaum**. Just last September, the Nurse Training Amendments of 1979 were enacted into law with the approval of the President. Now, less than 6 months later, almost 50 percent of the money available for 1980 is being recommended for rescission. Particularly hard hit will be the nursing scholarship programs. More than 25 percent of the scholarships have gone to minority students, and more than three-quarters of them went to students from families with less than $10,000 income.

In light of the above, does your statement that we need to strengthen programs for the disadvantaged not apply to nursing?

Dr. **Davis**. We have in the 1980 budget money for the training of nurses. In the President's 1981 budget we had $17 million for training nurse practitioners. We have additional money in the budget for nursing special projects. We feel that this is adequate both to encourage more nurses to go into the nurse practitioner area to provide more primary care and to provide special incentives in areas of greatest need.

Senator **Metzenbaum**. Dr. Davis, I have some grave concerns about your proposal for student assistance. The question is a rather lengthy one.

Tuition at private medical schools has increased by 180 percent over inflation since 1960. The percent of entering medical students who are from blue-collar families has decreased from 25 percent to 20 percent over the last 5 years. One-third of the dental schools report that students have been forced to drop out of school or have not been able to enroll after having been accepted because they could not finance their education.

Other students have rejected family practice, their initial career choice, because of their high level of indebtedness. Only 9 percent of medical students are from underrepresented minority backgrounds, and the figure is far less in the other health professions.

However, these students bear a disproportionate share of the service commitment under the National Health Service Corps scholarship program, that being 25 percent.

There are over 37,000 first-year students in health professions schools, but only 2 percent would be able to receive exceptional need scholarships.

This data, all seems to me, to suggest that the health professionals are dangerously close to becoming an exclusive club restricted to the white and wealthy. The administration's proposal will eliminate the health professions student loan program and force students to compete for service connected scholarships or borrow private capital which is not only drying up but will burden them with enormously costly payments.

Now, will this new policy of the administration alleviate the current problems or will it exacerbate them?

Dr. **Davis**. Mr. Chairman, we do maintain support to try to encourage more minority students to enter the health professions. We have maintained the program for exceptional financial need scholarships—the President's budget requests $10 million for fiscal 1981. We have retained the disadvantaged assistance program to give grants to a number of institutions to try to insure that minority students will be recruited and qualified to enroll in the health professions schools.

Senator **Metzenbaum**. Are not there only 700 scholarships that will be available?

Dr. **Davis**. Through the exceptional financial needs scholarship program, that is correct. These are first-year scholarships, the primary intent of which is to interest minority students in coming into medical school without that financial barrier. At the end of 1 year they are eligible for various scholarship and loan programs.

Senator **Metzenbaum**. This 700 is for all inclusive numbers for all of the professions. Is that not just a drop in the bucket and realistically would not the administration's program hurt the poor and the minority groups the most?

Dr. **Davis**. This is only one of the possible sources of support for minority students. We have the exceptional financial need program, as I mentioned.

Senator **Metzenbaum**. That is the 700 scholarships?

Dr. **Davis**. That is correct. We also have support for needy students through the National Health Service Corps program.

We feel that we should be able to get some service commitment for financial support to students in medical schools whether they are minorities or not, and so we tie a lot of the assistance to the National Health Service Corps Scholarship where we can get service commitments.

However, I think you have to look at this in the broader context of the income that these students are likely to earn at the close of their training. Physicians currently make very high incomes which are projected to increase over time. The financial cost of going to medical school represents a fairly small percentage of the total income that the physician can expect to earn.

I think Dr. Foley could add some additional information on that.

Senator **Metzenbaum**. In answering, you might also comment, Doctor, as to whether you think the level of indebtedness may affect career choice of some of the graduates.

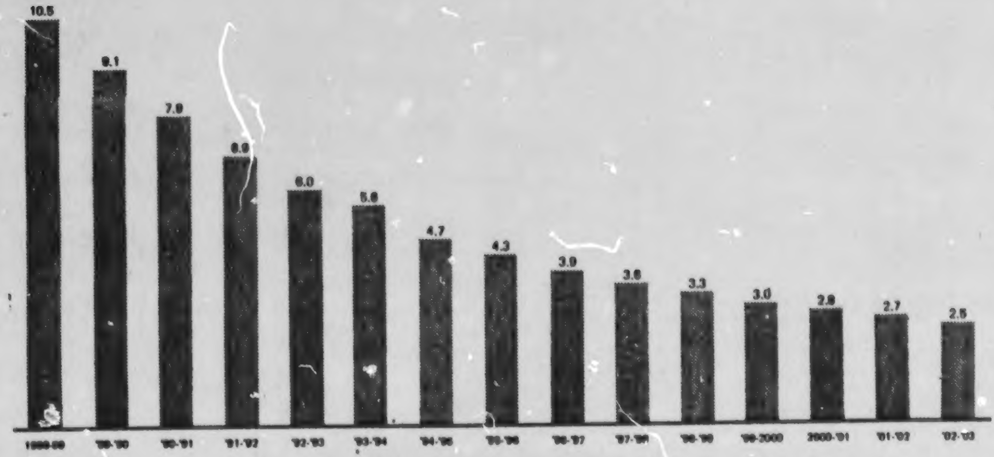
Dr. **Foley**. Yes, sir, Mr. Chairman.

Would the Chair accept a chart that we could follow together? It is a visual aid and it would be helpful, I think, to both of us.

[The chart referred to follows:]

LOAN REPAYMENT BURDEN RELATIVE TO INCOME UNDER LOAN FINANCED MEDICAL EDUCATION

Net Cost of Loan Repayment as Percent of Income



ASSUMPTIONS:

- Student finances *entire* medical education through loans starting in 1980, under a program similar to HEAL.
- Accumulated principal and interest over 7 years of medical school and residency is $10[illegible]87. This must be repaid over the next 16 years (starting 1987) at the rate of $1,425 per month (12% interest).
- First year physician earns 57% of peak year earnings.
- Inflation assumed at annual rate of 10%. Lower inflation rate could be partially offset by refinancing the loan at a lower interest rate.
- To determine net cost of loan, assume a marginal tax rate of 40%.
- Physicians who attend lower cost institutions or work part-time will face repayment burden of less than 9% of income during early years of repayment.

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Dr. **Foley**. Mr. Chairman, we looked at the current earnings of physicians in primary care and family practice medicine, and looked at the current rate of inflation. We looked at a rate of inflation of 10 percent over each year for the next several years, and looked at the income that the physician would have after 7 years of training. We also looked at the repayment schedule, assuming the extreme case of a student borrowing the entire amount of his school and personal needs—tuition, fees, and stipend. We looked at the cost that would be incurred from the beginning of medical school to the end of residency training, which would be $109,687. This would have to be repaid over 15 years. Starting in 1988, after completion of residency, the student would have to repay the loan at a rate of $1,425 a month, assuming a 12-percent interest repayment. We assumed that the first year a physician earns 57 percent of peak year earnings; we assumed the inflation rate, as I said, of 10 percent and assumed that physician earnings would keep up with inflation. A lower inflation rate could be partially offset by refinancing the loan at a lower interest rate.

We determined the net cost of the loan, assuming a tax deduction based on a marginal tax rate of 40 percent. We also note that if physicians attend lower cost institutions or work part time, they will face a repayment burden of less than 5 percent of income during the early years of repayment.

If we look at the chart, a student incurring a debt of $109,000 plus would have to pay 10.5 percent of net income beginning in 1988, after medical school and residency training.

Moreover, the payment decreases over the next 15 years so that by the time the physician has been practicing for 15 years, it is 2.5 percent of net income. We are also assuming that at the average peak earnings today of a person practicing primary care is $66,000. If earnings increase with inflation, they would rise basically to $400,000 by 1999.

What we are proposing and suggesting to the committee is something that really causes us to shift our own thinking about what it takes to pay for medical education in relation to the net return that a physician makes. We are finding that we cannot recruit physicians into the Veterans' Administration because in their first year of practice those physicians earnings can be at such a high rate that they can earn a salary much higher than the $55,000 that the Veterans' Administration can offer. We have had the same problem with the DOD. In HMO's salaries are being negotiated at $55,000 to $57,000 for beginning physicians. We know that physicians are able to recover in the first 2 to 3 years of their practice sufficient income to begin paying back a debt service at $109,000 which, at most, would be 10 percent of their income in the first year going to 9 in their second, 8 in their third, 7 in their fourth, 6 in their fifth, and so forth all the way down, as inflation increases their incomes in relation to the original value of the loan.

Senator **Metzenbaum**. Let me get this straight, Doctor. You are assuming an average of $66,000 income?

Dr. **Foley**. Today we are, peak earnings.

Senator **Metzenbaum**. At $66,000 income, if you pay it back at $16,800 a year, how can you say that would only be 10.9 percent?

Dr. **Foley**. We are assuming $66,000 starting this year increasing at 10 percent a year because of inflation so that by 1999, or the end of the century, we are at a $400,000 level for that same physician. In other words, we are looking at the——

Senator **Metzenbaum**. You are assuming that the physician will make $400,000 at the end?

Dr. **Foley**. Assuming the increases over the past 5 years that we have seen in physicians' salaries due to inflation, there is no breakpoint as far as we can see that would check the increase in physician incomes.

Senator **Metzenbaum**. Dr. Foley, I have to tell you that you amaze me.

I am flabbergasted that somebody would come before a committee and say that you assume that doctors are going to be earning $400,000—when is that?

Dr. **Foley**. By the end of the century.

Senator **Metzenbaum**. How much will a loaf of bread be then?

Dr. **Foley**. A loaf of bread at 10 percent is going to be extremely expensive.

Senator **Metzenbaum**. But we do not have 10-percent inflation. We have 18-percent inflation.

Dr. **Foley**. Then we are looking at something greater if you assume inflation will persist at that rate.

Senator **Metzenbaum**. $600,000 to $700,000?

Dr. **Foley**. That is correct.

Mr. Chairman, can I also suggest, if you look at the inflation in physicians' salaries in the last 5 years under current reimbursement rules, we have seen a comparable increase. All I am describing here are physicians coming out in family practice. I am not even touching the surgical areas or specialty areas where there are higher incomes.

Senator **Metzenbaum**. Let us talk about the doctor coming out now, let us not talk about what may happen in the future, because it is too scary.

Doctor, a physician getting out now, you say, would have an average income of $66,000?

Dr. **Foley**. Yes.

Senator **Metzenbaum**. And he would have to pay back at the present time if the rates were only 12 percent rather then the actual 18 percent, $1,245?

Dr. **Foley**. Yes.

Senator **Metzenbaum**. So if he paid no income tax at all, he would pay about 25 percent of his total income for his loan?

Dr. **Foley**. We are assuming though he is in a tax bracket which allows that payment basically to be a 40-percent tax writeoff.

Senator **Metzenbaum**. I thought that was very interesting, Dr. Foley, that you assumed that he had a marginal tax rate of 40 percent but you did not take into account that he has to pay taxes on that $66,000. I would guess that would be something in the area of at least $25,000, do you not think?

Dr. **Foley**. I think we could come back with the chart and look at it exactly in terms of the figures that we are talking about. I would be glad to, Mr. Chairman, for the record.

Senator **Metzenbaum**. But you made no assumption even though you made six other assumptions, that he was going to pay any taxes when you concluded that he would pay 10.9 percent.

Dr. **Foley**. No. We assumed that he would pay taxes, too.

Senator **Metzenbaum**. I do not see that. If you did, then how can you possibly *get to that figure?*

Dr. **Foley**. Let me come back for the record. We have a very detailed paper. It goes through it very carefully and I would be pleased to furnish it.

[The information referred to follows:]

Estimates of Loan Repayment Burden Relative to Income Under Loan Financed Medical Education

The purpose of this paper is to provide some indication of the magnitude of repayment burden that might exist for a young physician who has financed his or her entire medical education by loans under a Federal program similar to the Health Education Assistance Loan (HEAL) program. It is based on a set of very specific assumptions for a number of critical variables, such as future physician earnings, general inflation levels, loan repayment periods, and interest rates, which are described in the paper. It is important to keep in mind that the results of any analysis aimed at projecting developments more than 20 years in the future is subject to substantial caveats and uncertainty. This is particularly true of the analysis presented here, since the results are especially dependent on and sensitive to future economic developments, which are particularly different to foresee at the present time. Consequently, the results should be viewed with caution and in full recognition of the specific assumptions made.

The report was prepared by Jack Rodgers, Ph.D., of the Division of Health Professions Analysis, Howard V. Stambler, Director.

Introduction

Attending medical school can be very expensive, with typical private tuition and fees running over $6,000. In fact, average total expenses for a medical student at a private school are estimated to be $10,294 per academic year.[1] There is thus general concern that some qualified students, especially those from minority and low income families, may not be able to manage such a large outlay during the four years of medical college.

On the other hand, physicians earn large incomes relative to other professionals. In fact studies show that even after subtracting the costs of attending medical college, physicians earn considerably more over their lifetime than other high status occupations.[2] Of course, many years pass between entry to medical school and the establishment of a successful practice,[3] and a student financing his or her expenses by borrowing, will begin repayment years before peak earnings.

Total Amount Required for College

Since expenses are not identical for all medical students, several cost estimates will be considered. The National Health Service Corps (NHSC) scholarship program paid $5,467 for tuition and fees per student plus $6,379 for stipend and expenses during the academic year 1979-80. Table 1 shows how this amount is assumed to grow through inflation to $16,349 in academic year 1983-84.[4] Table 1 also shows expenses at private and public medical colleges through academic 1983-84. 5/ It is interesting to note that total expenses at a public medical college are roughly half the amount paid to a NHSC scholarship recipient, many of whom attend the higher cost private institutions.

In order to obtain a "high" estimate of the total amount which must be borrowed for medical school, estimates were made for the student with expenses similar to the NHSC scholarship recipient who finances his or her entire medical education through loans. 6/ Table 2 shows how principal and interest accumulate over the seven years of medical school and residency. In June 1988, when it has been assumed that repayment begins, the physician will face a staggering $119,963 in principal and accumulated interest which must be repaid over the following 15 years at the rate of $1,425 per month. The total repayed over the 15-year repayment period is therefore $256,500.

Before any conclusions can be drawn about the burden of this amount, however, several caveats must be made. First, use of the NHSC scholarship costs as a proxy for the amount of all loans needed by students may serve to overstate the actual amount of the loan needed. A public medical school student would have entered the repayment period with roughly a $60,655 debt (as opposed to the $119,963 debt for a private medical student, and monthly payments of $721, or half the amount shown in Table 2. Second, most students have an opportunity to pay for some of their expenses through part-time work, summer jobs, savings or other means. Third, the principal which has accumulated over the years at 12 percent interest is also being reduced by inflation, which has the effect of reducing its impact. Fourth, physicians have relatively high starting salaries with which to meet the monthly payment. Finally, interest expenses are tax deductible. For the high income taxpayer, net interest payments would be roughly 60 percent of the amount actually paid. (Income levels presented are net income before taxes.)

Prospective Earnings for a Future Physician

In order to put the $119,963 of loan debt into clearer perspective, it must be compared to the earnings from which principal and interest must be paid. Obviously, any attempt to estimate future physician incomes involves some heroic guesses. However, the estimates presented below are believed to be relatively conservative and assume only that their incomes will increase in line with overall inflation. 7/ Estimates of future income are restricted to primary care physicians, whose incomes are generally lower than those of specialists.

In 1978, the average earnings of physicians in primary care was $57,282. 8/ From data on age/earnings profiles, this implies a peak income of $66,014. 9/ Table 3 shows that in the first year of practice a physician earns 57 percent of this peak figure. The figures in Table 3 show how the $66,014 peak earnings statistic is adjusted to reflect both the physician's age and the increases due to inflation. Assuming that incomes of physicians rise at a rate similar to the average increases for all prices, therefore, estimated annual earnings would top $400,000 before the end of the century. However, as stated, these figures do not necessarily reflect an improvement in the economic status of physicians. Under the rates of inflation assumed here, a mail carrier, for example, would earn roughly $130,000 by the year [illegible]

Burden of Loan Repayment

In order to assess the burden of debt repayment to the physican in early practice years, income must be compared with loan repayment for the first 15 years in practice. Table 4 shows the annual loan repayment as compared with a current dollar income of $109,667 during the first year of repayment. Since the interest charges are tax deductible, this implies a net cost of $11,481, or 10.5 percent of income (before taxes). 10/ During the 15 years of repayment the net cost rises to $16,746, but since physician incomes area are assumed to increase at a rate commensurate with inflation, this amount would represent only 2.5 percent of income by that year.

Although 10.5 percent of net income before taxes is a large debt burden, it should be noted again that this is a fairly high estimate of the total amount of the loans that would be needed by students. The physician from a typical public medical college would face only half as large a debt burden with a net cost of $5,805 or 5.2 percent of net income during the first year of repayment. Similarly, the physician who attended a private institution but worked part-time or summers would face a lesser burden. Finally, the physician who received partial support from scholarships, family funds or other sources would have a smaller repayment burden.

As is readily seen, the inflated figures in Table 4 are extraordinarily difficult to comprehend and are difficult to compare with the 1980 price level. Therefore, Table 5 presents figures in 1980 dollars. This shows that for physicians with NHSC level expenses who have financed their entire medical education with loans, their net income rises from $43,624 to $76,320 net of loan repayment (in 1980 dollars) during the 15-year repayment period. For those physicians from public medical colleges, net income rises from $46,146 to $77,600 during the 15-year repayment period. The loan repayment and net costs are also shown in 1980 dollars in this table.

Conclusion

Statistics presented in this paper indicate that completely loan financing a high cost medical school education can lead to repayment burden which is close to 10 percent of net income (before taxes) during the early years of practice. Physicians who attend lower cost institutions or work part-time will face smaller repayment burdens, of less than 5 percent of income, during the early years of repayment. Even those physicians from high cost institutions should realize incomes (net of loan repayment) of $40,000 or more (in 1980 dollars) during the early years of practice.

Endnotes

1. Calculated by Steve Cylke, Assessment Group, using data from the American Association of Medical Colleges (AAMC).

2. See Stephen T. Mennemeyer, "Really Great Returns to Medical Education?", Journal of Human Resources, Winter 1978, Vol 13 (1), pp 75-90.

3. Figures shown later in this paper indicate that roughly 12-15 years after to medical school earnings are 85% of peak.

4. George Crocker of the Division of Manpower Training Supoort (DMTS) estimates that tuition and fees will grow at an annual rate of 10 percent while the stipend grows at a rate of 7 percent. This implies an overall annual rate of 8.39 percent for the NHSC scholarship costs. In the Table 1, a 8.39 percent growth rate is also assumed to hold for total expenses at public and private colleges.

5. Private and public medical school total expenses include living expenses which are less generous than the NHSC scholarship stipend.

6. The HEAL program has a maximum annual loan of $10,000 and a maximum total loan of $50,000. The assumption is made that this is increased to meet rising total expenses.

7. Inflation is assumed to be constant at an annual rate of 10 percent. However, since interest rates and inflation are tied together, a low rate of salary increase with low inflation can be partially offset by refinancing the loan at a lower interest rate.

8. Salary for each primary care specialty weighted by proportion of active physicians in that specialty.

9. Obtained by Steve Cylke from unpublished thesis work at the University of Chicago.

10. A marginal tax rate of 40 percent was used in the construction of Table 4. This is probably a low estimate of the combined state and federal income tax rate for high income professionals.

Table 1

Total Expenses for Medical School a/

Academic Year	NHSC Recipient	Private Medical College	Public Medical College
1979-80	$11,847	$10,294	$5,990
1980-81	12,840	11,157	6,492
1981-82	13,917	12,092	7,036
1982-83	15,084	13,105	7,626
1983-84	16,349	14,203	8,265

a/ For the NHSC recipient total expenses include tuition and fees plus stipend. The private and public medical college include tuition and fees plus room, board and other direct costs. Costs are inflated at percent per year.

b/ Expenses for state resident.

Sources: Health Resources Administration and American Association of Medical Colleges.

Table 2

Accumulation of Debt for Principal and Interest by Medical Student with Expenses Similar to NHSC Scholarship Recipient

	Tuition and Fees and Stipend a/	Loan Balance from Previous Year	Interest	Total
1980-81	$12,840	$ 0	$1,346	$14,186
1981-82	13,917	14,186	3,258	31,361
1982-83	15,004	31,361	5,559	52,004
1983-84	16,349	52,004	8,310	76,663
1984-85	0	76,663	9,722	86,385
1985-86	0	86,365	10,956	97,341
1986-87	0	97,341	12,345	109,686
1987-88 b/	0	109,687	10,277	119,963

a/ Tuition, fees and stipend are assumed to be received in two payments-September 1 and January 1. Interest is at an annual rate of 12% compounded monthly.

b/ The 1987-88 "year" is the 9 months from end of residency to the date when repayment begins.

Table 3

Estimated Annual Earnings for Private Practice Physician
in Primary Care Who Begin Practice in September, 1987

Year	Ratio of Earnings to Peak	Inflation[a] Factor	Estimated Annual Earnings [b]
1987-88	.57	2.48	$ 93,159
1988-89	.61	2.72	109,667
1989-90	.65	3.00	128,547
1990-91	.69	3.30	150,100
1991-92	.73	3.62	174,684
1992-93	.78	3.99	202,683
1993-94	.81	4.39	234,531
1994-95	.85	4.82	270,723
1995-96	.87	5.31	304,804
1996-97	.89	5.84	342,991
1997-98	.91	6.42	385,769
1998-99	.93	7.06	433,674
1999-2000	.95	7.77	487,301
2000-2001	.96	8.55	541,672
2001-2002	.97	9.40	602,044
2002-2003	.98	10.34	669,075
2003-2004	.99	11.37	743,335

[a] Earnings levels are assumed to increase at the same rate as inflation, or at an annual rate of 10%.

[b] Earnings = (Earnings Ratio) * (Inflation Factor) * (66,014).

Table 4

Loan Repayment Compared to Physician Annual Earnings (Current Dollars)

Year	Net Income b/	Loan Repayment	Net Cost c/	Net Cost as Percent of Income	Income Net of Repayment
1987-88a/	$ 93,159	$ 0	0	0.0	93,159
1988-89	109,667	17,106	11,481	10.5	98,186
1989-90	128,547	17,106	11,636	9.1	116,911
1990-91	150,100	17,106	11,810	7.9	138,290
1991-92	174,684	17,106	12,007	6.9	162,677
1992-93	202,683	17,106	12,228	6.0	190,455
1993-94	234,531	17,106	12,477	5.6	222,054
1994-95	270,723	17,106	12,756	4.7	257,967
1995-96	304,804	17,106	13,074	4.3	291,730
1996-97	342,991	17,106	13,430	3.9	329,561
1997-98	385,769	17,106	13,831	3.6	371,938
1998-99	433,674	17,106	14,284	3.3	419,390
1999-2000	487,301	17,106	14,794	3.0	472,507
2000-2001	541,672	17,106	15,368	2.8	526,304
2001-2002	602,044	17,106	16,016	2.7	586,028
2002-2003	669,075	17,106	16,746	2.5	652,329
2003-2004	743,335	0	0	0.0	743,335

a/ The 1987-88 "Year" is the 9 months from the end of residency to the date when repayment begins.

b/ Net income before taxes.

c/ Allows for extra tax deductions for interest on loans, but not general income taxes.

Table 5
Loan Repayment and Physician Net Income
(1980 Dollars) a/

	Net Income b/	Loan Repayment	Net Cost	Net Cost as Percent of Income	Income Net of Repayment
1987-88 c/	$34,147	$ 0	$ 0	0.0	$34,147
1988-89	48,725	7,600	5,101	10.5	43,624
1989-90	51,920	6,909	4,700	9.1	47,220
1990-91	55,115	6,281	4,337	7.9	50,779
1991-92	58,310	5,710	4,008	6.9	54,302
1992-93	61,505	5,191	3,711	6.0	57,795
1993-94	64,700	4,719	3,442	5.6	61,258
1994-95	67,895	4,290	3,199	4.7	64,696
1995-96	69,493	3,900	2,981	4.3	66,512
1996-97	71,090	3,545	2,784	3.9	68,307
1997-98	72,688	3,223	2,606	3.6	70,082
1998-99	74,286	2,930	2,447	3.3	71,839
1999-2000	75,883	2,664	2,304	3.0	73,579
2000-2001	76,682	2,422	2,176	2.8	74,506
2001-2002	77,481	2,201	2,061	2.7	75,419
2002-2003	78,279	2,001	1,959	2.5	76,320
2003-2004	79,062	0	0	0.0	79,062

a/ All figures were adjusted to reflect a 10 percent rate of inflation. The 1978 estimates of physician income were inflated to 1980 dollars and the loan repayment costs were deflated to 1980 dollars. For simplicity the rate of inflation is assumed to be 10 percent.

b/ Net income before taxes.

c/ Income for nine month period before repayment begins.

Senator **METZENBAUM**. Well, I am not going to belabor the point in the interest of time, but I must say that I think your figures are absolutely unbelievable and I think maybe you ought to support them with further documents.

Dr. **FOLEY**. We would be pleased to, and we have presented the figures to you in the way we have because they are stark. We have looked at the rate of increase in physicians' income in the past 5 years.

I think the second part of your question was how will this affect the recruitment of minorities.

I think we need to inform the minority population in this country as well as the majority about the incomes that physicians make in this country, we need to sit down with the physicians and the bankers to see whether there is a way that tuition and student support can be financed because clearly medicine is a very profitable profession to enter.

Senator **METZENBAUM**. No question about that, and maybe that is a good argument for national health insurance, which is the subject for another day's hearing.

Dr. **DAVIS**. I believe the other part of the question had to do with indebtedness and career choice, and I would like Dr. Martin to respond to that.

Dr. **MARTIN**. There have been a number of anecdotal cases, and some reported findings, saying that indebtness does have an effect on career choice. I think that needs to be put in the context of a large amount of work that has been done over the last two decades since the fifties—for example, "Boys in White", on factors affecting career choice and location. The locational choice of physicians depends on their medical training, role models, and residencies. I think to establish any firm linkage between the indebtedness and career choices as a point of public policy is a problem unless one says that indeed other factors in career choice are important and that we will deal with substantial factors which affect those career choices and preferences. These would not be indebtedness which is only a small part of the equation.

Senator **METZENBAUM**. Senator Schweiker.

I may submit additional questions to you in writing. I assume you will be good enough to respond.

Senator **SCHWEIKER**. Thank you, Mr. Chairman.

In looking at the administration's proposal, my concern is that we present a critical dilemma to a student who either has to go into some kind of service, and only 5 percent of the people or less can go into National Health Service Corps, or they have to take on this overwhelming debt.

Dr. Foley, as I look at your chart, is this chart—well, let me go to the first question about it.

Forgetting the present interest rate problem, which obviously obviates this chart, this chart is working at 12-percent interest.

Let us take all your present assumptions. While it is true your figure of $109,000 represents the money that they owe at the end of their residency, what you do not show in that figure is the interest they still have to pay in the future?

Now, if you take your own figures, that is $1,425 per month for 15 years. You figure it out, it is a quarter of a million dollars that they are paying back. They are paying back $256,500. It is true at the time the residency is completed your debt is only $109,000, that is because you have not paid interest yet on what you still owe. When you pay the interest on what you still owe, that student is paying $256,000 for his medical school education, Dr. Foley.

Do you follow my point?

Dr. Foley. I do, yes.

Senator Schweiker. Well, that gets pretty expensive, a quarter of a million dollar loan, and that is at 12-percent interest.

Let us take it at 18 percent. You are talking $384,000 debt that people have to assume for going to medical school.

Is that not a little unrealistic? Who is going to jump into over a third of a million debt to go to medical school, that is what disturbs me, and I am not even compounding the interest now. I am figuring 12- to 18-percent interest at straight line, too, which is wrong. So it is skewed in your favor. That is almost $400,000 just by using your assumptions and your figure except for the interest rate.

Dr. Foley. Senator, excuse me, but we are also assuming that the physician's income rises at a rate similar to the average increase in all prices. We are looking at the debt service that physicians are going to have during the 10 years after they complete their training. We also are looking at the net income that these physicians are going to have in that same period of time. We are joining those two amounts together, and we are looking at the results fairly seriously.

If you just focus on the debt service, it biases your understanding of what is happening.

Senator Schweiker. You have a 12-percent figure here, but I believe your legislation proposes that we take off the limit on interest rates; that we, in essence, follow the market, is that correct?

Dr. Foley. Yes, that is correct.

Senator Schweiker. So this will fluctuate whatever the market is and, of course, if it is 17¾ percent, and that is the prime rate, I cannot imagine banks are going to be loaning students prime rates, at least they normally have not. So I just have to believe that these are even conservative assumptions when you are talking—well, $400,000 with compounded interest. I wonder who is going to go into medicine at a $400,000 rate?

It is true that it is but a percentage of their income ultimately, but I believe that a student who is looking at a debt of $400,000 for the first 15 years of his career, is going to think twice about going into the medical profession. That is my whole point.

Dr. Foley. We have seen only a small downturn in the number of applications for medical schools. The competition for the number of school slots is extremely intense as we both know.

I think the question is how do we reach the low-income population or the middle-class population to see whether or not they want to finance their education this way.

Senator Schweiker. Maybe you have not seen any downturn but now you are wiping out capitation grants. I will not get into that argument because I have been in that. We lost the battle.

Chairman Magnuson opposed me and we lost on the floor. So there is another factor to this whole equation what somebody is going to have to pay in lieu of capitation grants. So that you have the capitation grant issue here, that is going to give another boost to the cost. So that you have another factor in terms of capitation results. Capitation grants have served the purpose of holding down some of these tuition rises and costs so that the lower- and middle-income people can afford it. But when you take capitation out of it, then you put a new element that was not there when you say you have not seen any people turn away from medicine as a career.

I just wonder if we are not putting tuition up where you will see people looking elsewhere?

Dr. **Foley**. Over the last 3 years there have been increases in tuition costs at the same time that capitation has been held relatively constant, as you well know. We do not see capitation as having held down the increase in tuition in the medical schools in the last 3 years, nor even prior to the cuts in capitation. I think that is important. I would also admit that the cut in capitation will cause a further increase in tuition.

Senator **Schweiker**. If we can only finance 5 percent, or whatever it is, on the Health Service Corps scholarships, why do we not subsidize interest rates? Why do we not take the money that we were putting into capitation and do, as my bill does, which is put a limit of what a student has to pay in interest so that he has a known entity. If we do not want to pay capitation, which is obviously the Government's position, why do we not pay that money in giving the student some kind of assurance that his loan percent will not fluctuate and that he will have some stable source of loan funds.

What is wrong with a interest subsidy in handling this problem other than that it costs money, but so do a lot of other things?

Dr. **Foley**. We feel, in terms of priorities in the training of health professionals, that this is not an acceptable cost for the Federal Government to incur.

Senator **Schweiker**. Let us look at the other priorities.

If this committee authorizes $93 million for National Health Service Corps scholarships, how many scholarships would be offered? How many people are we going to help under the Health Service Corps scholarship program?

Dr. **Foley**. 6,701 in fiscal year 1981.

Senator **Schweiker**. 6,701, out of a population of what?

Dr. **Foley**. Out of a population of—in terms of the number of students in medical schools?

Senator **Schweiker**. Yes.

Dr. **Foley**. There would be about 5,000 medical scholarship recipients out of a total of somewhat over 60,000 medical students.

Senator **Schweiker**. What is that?

Dr. **Foley**. The total number of medical students is somewhat over 60,000, Mr. Chairman. The number of first-year students was 16,134 in 1977–78. If we take that and extrapolate it for the 4 years, we are above 60,000 students.

Senator **Schweiker**. So the 6,701 would apply on that base then of 60,000, is that what you are telling me in answer to my question?

Dr. **Foley**. The 5,000 medical student scholoarships would be out of 60,000 plus total medical students.

Senator **Schweiker**. You are not counting osteopathic and dental students in your base, is that correct? Your base would be larger, I believe, if you did.

Dr. **Foley**. We are counting medical students only.

Senator **Schweiker**. At 60,000?

Dr. **Foley**. The 6,701 awards that I mentioned do include the other health professions.

Senator **Schweiker**. Yes, they include them, but your base does not include them?

Dr. **Foley**. No, my base of 60,000 does not include them.

Senator **Schweiker**. What would be the total—I am trying to figure out what percent we are going to help this way. We are going to saddle people with a $400,000 loan when they get out of medical school, and I am trying to figure out who would not get saddled and how many we are going to favor.

Dr. **Foley**. We will get you the exact percentage, Senator Schweiker, for the record.

[The following was received for the record:]

PERCENTAGE OF SCHOLARSHIP

The proportion of medical students receiving National Health Service Corps Scholarships is currently about 8 percent.

Senator **Schweiker**. OK.

It is a pretty small percentage, I might say. We have found in the past that if we recruit volunteers for the underserved areas, that we have a higher retention rate in terms of staying on in the underserved areas as opposed to, in essence, drafting them because they signed on for national health service scholarship programs. My question is, Why do we not use volunteer recruitment which has shown that because of motivational factors that people will stay in the areas of underserved medical care rather than scholarships that so far have not indicated a high percentage of retention?

Dr. **Davis**. We do have a strategy of supporting the Corps both through scholarship obligees and through volunteers. We expect by 1990 to be continuing to have about 2,300 volunteers per year. We are meeting a sizable proportion of the overall need through volunteer replacements.

Dr. **Martin**. Senator Schweiker, I think it might also be important to add that there is a limitation to how many volunteers can be recruited in any given year. Although there may be some 12,000 to 14,000 people coming out of medical school, even with the most aggressive of efforts in recruiting, we have only been able to recruit 200 or 300 physicians as volunteers in the National Health Service Corps. So there is a limitation to the total numbers that we get.

Second, the volunteer program is heavily influenced by the individual choice, and I think it can be stated categorically that while the retention is high, the areas that the individuals choose to go to may not be in the areas of greatest need. If it were not for the scholarship program, we would have difficulties in staffing areas where volunteers are not willing to go.

Senator **Schweiker**. You are saying you do not want to subsidize the interest for student loans for medical students, yet you are saying you want to pay salaries of people when they get out. Why do we not take that money for interest subsidies and loan forgiveness and let lower and middle-income people who might have some desire to go to some of these underserved areas, why do we not put the money there where we might get more motivation for people to stay in the urban areas with a lower income background? What is wrong with that?

Dr. **Martin**. I think that there is a great deal of data showing that those individual students to whom you are referring indeed, even with their medical educations heavily subsidized, very small out-of-pocket expenditures, and regardless of class of background, when they leave medical school simply are not going into the areas that we are talking about. There have been 8,000 students that could have taken advantage of loan repayments. Of those 8,000, 1,000 went into shortage areas and the program, and of those, 700 were in the Indian Health Service National Health Service Corps. Three hundred out of 8,000 students, I think, fairly stated, uncorrected by income background or level of debt, elected to go into those shortage areas without assistance from the Federal Government, and I think the cry we hear from many communities is that while we hear from many that these students want to come out here to practice, they simply are not going there. And I think the numbers bear out very quickly that in the worst areas of this country—especially the 5 to 10 percent of the worst shortage areas—the service motivations somehow disappear between the freshman year and the third year residencies.

Secondarily, when they go out, we have found that they have a significantly lower rate of medicaid patients. Physicians who graduated in the last decade have a much lower medicaid practice than those in the last 20 or 30 years. The private mechanism, which includes salaried physicians precludes the availability of care for those high risk populations.

Senator **Schweiker**. Well, my time is running out, but I do have one more question that I would like to ask. I know that I talked to Dr. Foley about this at an earlier hearing, but I want to talk to Dr. Davis, too, because part of the administration's approach is to phase out the aid to nursing schools on the basis that we do not need more nurses.

As I told Dr. Foley, every hospital that I visited volunteered to me that they have a bounty program and that if you recommend a nurse for their hospital, you get a $100 bonus or $200 bonus or $300 bonus if they hire that nurse.

It is hard for me to keep believing the administration's figures that keep coming out saying that there is no nursing shortage, that we do not need nurses when they have a bounty system going on all around. It is just so contradictory and completely opposite of the market which says, hey, if you tip us off where we can get a nurse, here is $100 or even $200. How do we justify phasing out support for nursing when every indication is that the nurses are not there or we would not be offering $100 or $300 bonuses?

I do not know of any other health profession that is giving that kind of bonus right now.

What is your response to that?

Dr. **Davis**. As we looked at the nursing situation, the overall problem does not seem to be one of aggregate numbers. The number of nurses trained in this country has climbed dramatically in the past.

We expect there to be over a million nurses trained by 1985 which far exceeds the demand. But the basic problem we are finding is that a high proportion of nurses are not active in the nursing profession. About three-fourths of trained nurses actually practice.

The real problem seems to be not so much aggregate numbers of nurses trained or produced as it is trying to retain them in the nursing profession. There are a number of factors that enter into this. Some of it seems to be the wage structure, some of it seems to be the fact that there are opportunities for women to enter other occupations which are becoming more attractive, some of it has to do with morale in current nursing jobs. We think the emphasis should be on trying to figure out what causes nurses to leave the profession for other professions or not to stay in the work force. That is where we should place our emphasis rather than simply continuing to add more and more numbers of nurses.

Senator **SCHWEIKER**. I will concede, and I did this with Dr. Foley, that obviously what we pay nurses and the challenges in the other professions is certainly a factor, and I concede that. But I still do not see how that is relevant to cutting down the input to nurses in the first place.

If we know that more are going to other occupations and move up in the economic ladder as their reason for leaving the profession, that does not seem to me to be a reason to cut down the input and to cut down attracting people. If you cut down the input 15 percent or 20 percent, you are going to make your problem worse.

We should do more to make nursing attractive and to raise salaries, but is that any reason to cut down the input and to narrow the choice and to make the field even smaller to pick from? It would seem to me that that would complicate the problem rather than help it. Even if your presumption is true on that score.

Dr. **DAVIS**. Well, we are really not anticipating a reduction in the number of nurses trained, even in the absence of Federal support for assistance to nursing schools. We expect that the overall supply will continue to grow from about 973,000 full-time equivalent nurses in 1980 to about 1,135,000 to 1,167,000 for 1985. We do project continued growth in the number of nurses even in the absence of the kind of support nursing schools have received in the past.

I think it is wasteful to train nurses who choose another occupation or drop out of the work force. We should be concentrating our energy on seeing that those nurses are active in the work force.

Senator **SCHWEIKER**. I know our time is running out with the nurses.

Senator **METZENBAUM**. Thank you, Dr. Foley, Dr. Davis, and Dr. Martin.

Our next panel consists of Dr. Edward J. Stemmler, dean of the University of Pennsylvania School of Medicine, representing the Association of American Medical Colleges; Dr. H. Charles Moore, president of Kirksville College of Osteopathic Medicine, representing the American Association of Colleges of Osteopathic Medicine; and Dr. Wallace V. Mann, Jr., dean of the University of Mississippi

School of Dentistry, representing the American Association of Dental Schools.

The Chair indicated earlier that he is going to hold the witnesses to 5 minutes, and by reason of the verbosity of the Chair and the ranking minority member both, which joined together to take much of the time, and the Chair was particularly at fault. I am going to hold you to 5 minutes each.

Senator **Schweiker**. I want to say that I am pleased to welcome Dr. Stemmler, who is dean of the University of Pennsylvania School of Medicine.

STATEMENTS OF EDWARD J. STEMMLER, M.D., DEAN, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY DR. COOPER; H. CHARLES MOORE, PH. D., PRESIDENT, KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE, REPRESENTING THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE; AND WALLACE V. MANN, JR., D.M.D., DEAN, UNIVERSITY OF MISSISSIPPI SCHOOL OF DENTISTRY, REPRESENTING THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS, A PANEL

Dr. **Stemmler**. Thank you. I am Dr. Edward J. Stemmler, dean of the University of Pennsylvania School of Medicine. Dr. Cooper and I represent the Association of American Medical Colleges.

I would first like to assure you that my testimony this morning, as well as the lengthy backup statement submitted for the record, reflects the overwhelming consensus that prevails within the association.

Let me summarize very briefly our positions on the financing of medical education.

Medical schools must provide the public first-class physicians through high quality medical education. Within the limits of available first year places, access to medical education should be determined only by the availability of the applicants and their probable capacity to be conscientious, competent, and compassionate physicians. Adverse selection, based on race, creed, color, gender, handicap or economic status should never occur. The cost of the system for medical education should be equitably borne by all of the students. The schools stake their claim on Federal resources on the fact that they are engaged perennially and to a significant degree in public service activities that impact the whole Nation. Therefore, the Federal Government should: provide a balanced portfolio of student assistance programs; often basic support to educational institutions; and make available cost reimbursement awards for the conduct of specific tasks to meet the high priority national goals and objectives.

In view of their future high income potential, medical students should be expected, for the most part, to finance a substantial part of their education, out-of-pocket or through borrowing. The economically disadvantaged need support at the time they enter medical school and their access to medical education and the choice of a medical career will depend on the program of scholarships for exceptionally needy students.

Student assistance programs should be needs based. They should assure availability of support through the period of education and they should be structured to keep debts to reasonable and manageable proportions until the completion of residency training. Service payback programs should not be viewed as—or used for student assistance. Loan forgiveness incentives should be explored to meet service needs. The attractive features of S. 2144 and S. 2375 could after appropriate selection and modification yield a sound program. However, under no circumstances should the Federal Government recover the enormously valuable student loan funds now available to the schools as proposed in these bills and by the administration.

Institutional support is a critical need of the schools. Committed to a myriad of educational research and patient care activities, all of which contribute to the improvement of the Nation's health, schools respond to a host of pressing national social problems. Without it to integrate their many discrete activities into a more coherent, orderly, effective program or to compensate for the failure of external sponsors, to reimburse costs, they will be forced to discontinue many, if not all, of their joint efforts with the Government.

Tuitions, a theoretically available source for such funds in private but not in public schools, are already staggeringly high. Medical education is so expensive that without institutional subsidies, it is beyond the economic reach of many altruistic and well-motivated students. Institutional support has paid off handsomely to all parties—government schools and the public.

For want of a relatively small investment, the administration would break a bond with institutions whose power as agents of social change has been repeatedly demonstrated.

We believe that the mechanism for institutional support proposed in S. 2375 is the better crafted for the desired purposes.

Special project grant programs complement the other mechanisms for Federal assistance to medical education. Solutions to specific social problems can be sought through cost reimbursement contracts with institutions capable of doing the job. These programs are ideal for exploiting the rich diversity represented among the schools. However, they seldom reimburse full cost and require that the schools subsidize them from limited institutional resources.

Again, both bills incorporate a range of special project programs and we recommended that the list be broadened and diversified and that the authorization ceiling be increased.

We hope that all construction authorities can be retained and their authorization ceiling increased as well. One especially serious need is for ambulatory teaching facilities in primary care and in addition there is a growing need to rehabilitate substantial elements of the educational plant.

I would like to speak to S. 2378, which proposes in part to modify the Immigration and Nationality Act with respect to exchange visitor visas for foreign medical graduates. We support the extension in the allowable duration of stay and the additional criterion for identifying health shortages. We strongly oppose two other provisions. The extension of the VQE waiver period and the award of payback of the health corps scholarships for periods of internship, and residency in hospitals newly defined as shortage areas.

We want to express our willingness to work with the majority and minority and the administration in producing a bill, and we thank you, Mr. Chairman, for your time.

[The prepared statement of Dr. Stemmler follows:]

aamc association of american medical colleges

Statement of the

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

on

The Health Professions Educational Assistance
and Nurse Training Act of 1980
(S.2144)

and

The Health Professions Training and Distribution
Act of 1980
(S.2375)

and

The Health Care Management and Health Care
Personnel Distribution Improvement Act of 1980
(S.2378)

The Association of American Medical Colleges (AAMC), the national voice for all of the 126 operating U.S. medical schools, more than 400 of the major teaching hospitals, and over 60 academic and professional societies is pleased to have the opportunity to share with the Subcommittee its views on S.2144, The Health Professions Educational Assistance and Nurse Training Act of 1980; S.2375, The Health Professions Training and Distribution Act of 1980; and S.2378, The Health Care Management and Health Care Personnel Distribution Improvement Act of 1980. The interest of the Association's constituency in those bills hardly needs elaboration. It is comprised of the individuals and institutions--the medical schools and their faculties, the teaching hospitals and their professional staffs--that are engaged on an every day basis in the complex and intertwined processes of teaching, research, and patient care that in the aggregate constitute medical education.

The Process for Developing the AAMC Position

Shortly after the enactment of P.L. 94-484, the Association appointed a representative group of distinguished medical educators to re-examine carefully and comprehensively the interface between medical education and the Federal Government, with an eye to reaffirming old, or defining anew, appropriate positions on this issue for our times. This Task Force on the Support of Medical Education, initially chaired by Dr. Stuart Bondurant, presently Dean of the University of North Carolina School of Medicine and later by Edward J. Stemmler, M.D., Dean of the University of Pennsylvania School of Medicine, has a large membership that includes medical school deans, teaching hospital administrators, medical school faculty members, medical students, non-medical school university officials, and a variety of "consumer" representatives. It is important for the Subcommittee to be aware that the Association's position as presented today: reflects a long process of internal discussion and debate; involves extensive interaction with a very large segment of the membership over an extended period of time; and represents the overwhelming consensus of the medical education community.

Specific comments on the bills under consideration begin on page 20. However, because of the great importance of health manpower legislation, it was considered essential to begin by placing current deliberations in the context of the history of medical education.

Background

The early history of medical education in the United States was turbulent and its status generally undistinguished until the second decade of this century. Multiple forces were at work, however, to upgrade it and in 1911, these culminated in the publication of the historic Flexner Report. Flexner's survey revealed the very wide gap between what medical education was and what it ought to be. It stimulated a series of reforms that led to a reduction in the number of operating schools from 165 in 1900 to 80 in 1925. In the following twenty-five years, the net number of operating schools remained constant, although about eight new schools opened and a comparable number closed.

The real change that ensued in the wake of the Flexner Report was an enormous improvement in the quality of medical education. A climate had been created in which public opinion supported an accreditation process that demanded uniformly high minimum standards for educational institutions that sought, or claimed the authority, to award the degree of doctor of medicine. The institutions that survived the upheaval that took place between 1911 and 1925: were predominantly university affiliated; were committed to as large a full-time faculty as possible, exclusively dedicated to teaching, research and the attendant patient care required for these activities; insisted that applicants meet high standards for admission and that students maintain high performance while in school; required that the preclinical curriculum involve scientific laboratory exercises; and featured a clinical curriculum that required extensive, supervised bedside and clinic contact between students and patients.

Until medical schools began, in about 1950, to grow again in number, those in operation were about equally divided between public and private sponsorship; schools chartered since 1950 have been predominately public.

The costs of medical education were relatively modest until quite recent times; room, board and tuition charges constituted an insuperable barrier to only the most impecunious students and institutional resources were almost invariably sufficient to assist the latter. However, the salaries for the faculties of medical schools must be reasonably competitive with the incomes of physicians in private practice and, as the latter began to climb, so also did expenditures for faculty salaries. Similarly, the costs of operating teaching hospitals tend to follow the general pattern of all hospitals but at a higher level, due particularly to a census composed predominantly of patients requiring tertiary care. Thus, economic events of the post World War II era began to place the medical education institutions of the country under increasing financial duress. The need for growth of the enterprise became progressively more obvious, while the wherewithall to accomplish it became increasingly more problematic.

The fact that new schools opened after 1950 were for the most part under the aegis of the states reflected the response of the latter to the twin demands of their citizens for educational opportunity and for more physicians to deliver health care. Long importuned for educational assistance, the Federal Government resisted any contribution to medical education until 1963. The medical schools had, of course, received substantial Federal support for biomedical research, beginning in the years immediately following World War II. It should be emphasized that these funds were granted specifically for research and their expenditure carefully audited for compliance with that purpose. Contrary to what has frequently been stated, these funds were neither intended for, nor used as "under-the-table" or indirect Federal support for medical education. Their sole impact on the latter process was to enable schools to add members to their research faculty, who, though largely funded out of Federal research funds, participated in the education of students in the discharge of their university commitments paid for by their university salaries. Research oriented universities were thus able, as an unavoidable---and not unwelcome---consequence of Federal research funding, to provide an enriched educational curriculum for their students.

Federal support of medical education initially took the form of student assistance, followed by matching grants for the construction of health educational facilities and eventually, beginning in 1971, institutional support to schools, computed on the basis of their enrollments---per capita, i.e., capitation.

The commitment of the Federal Government to the support of medical education coincided with, or actually lagged by several years, widespread national perceptions of: a severe impending shortfall in the availability of physicians; and a social imperative that access to medical education should be available to all qualified students, within the limits imposed by the available first year places, and irrespective of race, ethnic background, gender, or economic status. Thus, student assistance programs for needy, minority or women students, together with institutional support contingent upon enrollment expansion became major items in the armamentarium of Federal support. As the uneven national dispersion of physicians in geographic and medical specialty terms---with too few practitioners in rural and inner-city areas and with too few generalists and primary care specialists---emerged as a public concern, modifications were made in programs for student aid (e.g., the National Health Service Corp Scholarships), in the conditions for institutional support (e.g., primary care residency requirements) and in types of special project grants (e.g., AHEC's, family medicine, general internal medicine, general pediatrics). Inferrentially, then the strategy that the Federal Government adopted was to provide assistance to medical education for facilitating solutions to specific narrow targets of national scope and importance.

More recently, another significant source of revenue has emerged to sustain medical education. Members of clinical faculties, organized under practice plans, have contributed heavily from their earnings, derived from providing medical care to private patients, to the support of their own as well as other medical school departments. This funding source has grown rapidly and been highly welcome. However, the limits on its usefulness are real. These relate: to the reimbursement policies of health care delivery sponsors (medicare, medicaid, Blues, etc); to the adverse impact on scholarly activities that come from excessive diversion of effort to practice; and the extent to which faculty members are willing to subsidize their institutions.

Beneficiaries of Medical Education

In reviewing recent developments, the AAMC has been impressed with the need for and justifiability of marshalling support for medical education from all of its beneficiaries. It is easy to see how students benefit, in that education provides them entree into a well remunerated profession. Indeed, there are those who would place the entire burden of the cost of the education on the student. However, with these per student costs probably currently averaging $20,000/annum, exclusive of living expenses, this option is not generally viable.

The extraordinary commitments of the states to medical education indicate the recognition of the importance of medical schools to them. Since 1950, 38 of the 49 new medical schools that have been accredited and begun to operate have been public schools. In the more recent major expansion of school capacity, the states have by far and away played the major role. For example, in the decade from academic years 1965 to 1975, 66% of all new first-year places created were in public schools and, of the new first-year places created in new schools of medicine, 25% were in public schools. In academic year 1978, state support of public medical schools totaled $868 million and these jurisdictions provided an additional $77 million to private schools; these amounts account for about 39% of the total operating revenues of the nation's medical schools. Tuitions in public schools are well below those of private schools. Students in public schools, if charged the average annual tuition of private schools would have had to pay in 1979 an additional $185 million; this aggregate annual amount could be considered the value of partial scholarships funded by the states. The states have borne and are bearing an unusually large share of the responsibility for financing medical education.

The schools stake their claim on Federal resources on the fact that they are a national resource, engaged to a significant degree in public service activities that impact on the whole nation and thus merit Federal subsidy. Evidence to support this claim rests on several grounds:

- The health needs of citizens throughout the country are served by a system of medical education that uniformly produces highly competent physicians, based on national standards and thus warranting national support.
- The high degree of geographic mobility of physicians imbues them with the character of a national, rather than local, resource and justifies Federal subsidization of the schools which provide their education.
- Medical education deserves subsidy because it is far more expensive than other graduate or professional education programs, and is, in practical terms, beyond the economic reach of many able, altruistic and well motivated students.
- The Federal government entered into a partnership with medical schools to achieve commonly agreed upon public purposes, the accomplishment and maintenance of which require continuing mutual commitment.
- Fulfillment of specific legal entitlement commitments by the Federal government to the citizenry depend upon the availability of competent physicians in adequate numbers.
- Medical schools, engaged in a myriad of educational, research and patient care activities, all of which contribute to the betterment of the nation's health, require flexible funds to maintain their capacity to respond to national needs related to the pressing social problems such as expanding access to and containing the costs of health care.

These assertions require further explications to make clear the extent to which the phenomena described have national dimensions and affect a broad segment of the American public.

Physician competence of uniformily high quality throughout the nation is obviously an important desideratum, so that the public can reasonably expect to receive excellent medical care everywhere throughout the nation. Both residents and transients deserve assurance that they will experience a high degree of competence in their encounters with physicians. This objective has been achieved in this country through a system of medical education that endorses and accepts national standards of excellence. The national accreditation process has systematically discouraged the development of schools responsive to narrow urgencies for physicians of limited competence on the premise that the activities of a physician, once granted a medical degree or a medical license cannot be restricted in any practical way. A compromise of standards could and probably would rapidly destroy the reliance that now can be placed on the qualifications of medical practitioners. In this sense, the national government has a profound interest in the preservation of the existing system and a corollary obligation to support it.

Physician mobility is another aspect of this national system. Many physicians enter practice in localities and political jurisdictions other than those in which they received their undergraduate medical education, and provide services to populations that in no way contributed to their education. The Federal government, by contributing to each medical school, helps to equalize the disparate contributions to its support of the various beneficiaries of the medical education process. The Federal government is the only agency that can effectively perform this national equalization function.

The cost of medical education, as it has evolved in the United States, is disproportionately expensive, when compared either to graduate education in general or to education in other learned professions. The American system has two notable characteristics: intensive faculty-student contact, requiring a large faculty, to insure extremely careful evaluation of candidates for a degree that carries heavy social responsibilities; and education in the clinical sciences in a practical mode, with carefully scheduled, graded supervision both at the bedside and in the ambulatory clinic. In other countries, medical education is didactic, relying almost exclusively on lectures and demonstrations; medical education of this sort can be offered to large numbers of students by a small faculty at lower cost, Clearly, American (and Canadian) medical educators, both of whom rely on the same accreditation process, are convinced that the curriculum and style of education offered in this country are far superior; all available evidence suggests this conviction. The total costs of this education need to be met if the medical schools are to remain operational and continue to educate high-quality physicians. The Federal Government, by its support of medical education during the last 17 years, has assumed the role of helping to provide the nation a pool of highly trained and qualified physicians and, by its example, has encouraged other segments of society to undertake, to continue or to expand their support to the schools.

One potential alternative to subsidy consistent with the same quality of education -- the shifting of the costs to the students -- would have an extremely undesirable social impact since, for all practical purposes, it would limit access to the profession to the economically affluent. A frequently voiced objection to Federal assistance is that it is unjust for society to subsidize the education of individuals whose future incomes will be very large. This assertion fails to recognize the serious difficulty of transforming potential future earnings into a mechanism to assist either schools or students in the here and now. Students could only take advantage of future earnings by borrowing against them; in the present economy, unsubsidized borrowing would result in very substantial debt burdens that, in and of themselves, have seriously undesirable consequences. Schools could exploit potential future earnings of their students by further increasing already frighteningly large tuitions, forcing students to commit themselves to the repayment of even greater debt. Whether this sequence of events is in the public interest is highly dubious.

A partnership was established in 1963 between the Federal government and the medical schools, for the purpose of, at least in part, achieving commonly agreed upon public objectives. That agreement implicitly requires continuing mutual commitment by both parties. The Federal government has encouraged the initiatives of medical educators to undertake major changes in their programs, most notably to increase enrollments and to establish new schools, but also to engage in a multitude of new activities high on the nation's list of social priorities; expansion of resources and personnel for primary care is an example. The medical schools have been extremely responsible in discharging their commitments under this partnership. However, their effectiveness will be compromised and the quality of education seriously threatened without continuation of the Federal support which initially enabled them to respond. For example, the costs associated with expanded enrollment are recurrent; they continue by virtue of commitments the schools assumed for new faculty, expanded physical facilities, etc., and they are not offset by tuition. It is incumbent upon the government to hold up its end of the partnership.

Federal commitments of an entitlement character have been made by the government to the general public (in Medicare and Medicaid) and to special beneficiary groups (the members of the Armed Forces and their dependents, veterans, merchant seamen, etc.) that require for their discharge the availability of physicians of unquestionable competence in adequate numbers; a program of national health insurance, if enacted, would further substantially expand Federal obligations. The viability of all of these existing or future committments depends, or will depend, on a steady supply of physicians, a *sine qua non* for which is the continued existence of strong medical schools. These public medical care programs, while they clearly reimburse for physicians services, fail to include any provisions to assure an adequate supply of physicians. For this reason, it is appropriate for the Federal government to contribute to the support of medical schools.

Innovative responsivity to national health needs and problems has characterized medical school behavior throughout modern times. These institutions have participated extensively in a large number of government and private programs directed at improving health through: biomedical, behavioral and health services research; acceleration of technology transfer; education of physicians and other health providers; provision of health services to general and special populations, improvement in the health care delivery system, etc. Obviously, many of these program objectives coincide with those of the schools, with government or private sector sources assisting the schools to do what the latter wanted to do or, more often, actually had done, albeit on a more modest scale of their own accord. As is also the case for research activities, but to an even greater degree, the totality of the educational effort of a medical school can become very chaotic, incoherent and disorganized when a substantial fraction of its funding comes in the form of multiple, relatively small discrete awards for very specific tasks, many generated by independent faculty members or groups. Institutional support funds are desperately needed to enable institutions to integrate their many discrete activities into a more coherent, orderly and effective program to act as the mortar to hold the bricks together. In general, awards from both governmental and private philanthropy have covered less than full program costs; institutional cost sharing--voluntary or involuntary--has been a pervasive phenomenon, not limited to the research area. Thus, institutional funds which might serve the desired integrating function are diverted to subsidize government sponsored programs.

For institutions to develop or expand their capacity to identify and respond to public needs, stabilization of these institutions *qua* institutions is imperative. They house one of the nation's precious assets--faculty members of high intelligence, imagination, originality and problem solving capability, the principal potential sources for ideas that might assure responsiveness of the health care system to the needs of the nation. But unless these assets can be marshalled to concentrate on broad national issues and distracted from narrow preoccupation with some specific sponsored program, the actual contributions of the faculties of medical schools to the identification and solution of our country's problems will be far short of what they could otherwise be. In this context, past Federal contributions to the pool of educational funds allocable, within Federal guidelines, by the institution have substantially facilitated the ability of the medical schools to respond expeditiously to the many splendid program ideas that have emerged from a variety of sources, all seeking to find new ways to meet the health needs of our society. A General Accounting Office (GAO) study, entitled "Federal Capitation Support and its Role in the Operation of Medical Schools," confirms both the need for, and the responsibility with which, institutional support funds have been deployed. If the schools are to continue to serve this important function in the future with dispatch and effectiveness, broad-based institutional support that can be utilized to build and maintain this capacity is essential.

For all practical purposes, no alternative to the Federal government as a source of funds of this character is available to most of the nation's medical schools. Endowment income is small, already heavily over-subscribed, and likely to be preempted for essential academic needs to which external sponsors are rarely willing to contribute. As a result of inflation and revisions of the tax laws, income from the gifts of benefactors or from the grants of foundations is not large in most institutions and almost always earmarked for very specific tasks not necessarily related to social objectives. Tuition in many schools is approaching an absolute limit; moreover in most state schools, increases in tuition go to the state treasury rather than become available to the medical school. Thus without Federal investments, a highly desirable academic attitude toward, outlook upon, and dedication to social problems, as viewed from the national perspective and related to health, is likely to atrophy.

On the basis of its deliberations, the Task Force reached the following conclusions:

- The delivery of high quality education is the first and foremost responsibility of the nation's medical education enterprise.
- The prevailing educational system, costly though it be, should not be compromised; rather long-range plans should be developed to place it on a sound financial footing.
- The cost of the system for medical education should be equitably shared among the beneficiaries: students, general public and political jurisdictions--local, state, and Federal Governments.

- Access to medical education should be determined, within the limits of available first-year places, by the ability of the applicants and their probable capacity to be competent and compassionate physicians. Arbitrary exclusion on other grounds--economic status, race, ethnic origins, gender--has no place in the selection process.

It recommends that Federal Government support should:

- provide an appropriately balanced portfolio of programs to assist students to defray the costs of their education;
- offer flexible support to educational institutions; and,
- make available cost reimbursement awards for the conduct of specific programs (special projects) to meet high priority national goals and objectives.

Sensitive to the complex and delicate problems of operating an institution with multi-partite support and mindful of recent challenges to institutional autonomy by external sponsors, the Task Force gave extensive attention to the principles on which Federal assistance to medical schools should be predicated. The discussion and debate led to consensus on the following premises:

- Programs to achieve social objectives should be implemented primarily through incentives rather than through detailed specification of institutional operations.

- Programs should have reasonable continuity of purpose; should be developed in a manner that permits rational institutional planning; should recognize the lead time required for institutional change; and should avoid the institutional disruption created by major oscillations in available funding.
- Federal officials should recognize that, at least in the long run, socially desirable program objectives can be accomplished only if adequate care is given to the health and integrity of the responsible institution.
- Programs should permit institutional diversity within the framework of national objectives, and should accommodate the requirement for academic freedom with the imperative of accountability for public funds.

These recommendations of the Association emerge at a time when medical education is at a critical crossroads. It stands today as one of the most beleagured enterprises in our society, impacted by a series of actions originating from many quarters and without any evidence that any of the initiators have any sense of what any other is about. The catalogue of assaults perpetrated, or about to be perpetrated, by the Federal Government alone is impressive. Actions taken to reduce revenues include the following: reduction, perhaps to zero in capitation funds in both current and constant dollars; reduction--in constant, and perhaps soon in current dollars--in research project funds; reduction--in constant and current dollars; reduction -- in constant, and perhaps soon in current dollars -- in research project funds; reduction -- in constant and current dollars -- in research training funds; discrimination against teaching physicians in policies for reimbursement of physician services; selectively reduced reimbursement of teaching hospitals for routine hospital costs; and inequitable application of accounting conventions in the officially adopted cost principles for educational institutions. A comparable set of Federal decisions, by imposing seriously increased and unreimbursed costs on the institutions responsible for medical education, have placed these institutions under additional financial duress. Included in this litany are requirements to comply with regulations related to: institutional review boards; hazardous waste disposal; low-level radioactive waste disposal; carcinogenic chemical compounds; discrimination against women, minorities, the handicapped, etc; the Health Planning Act; good laboratory practices; clinical laboratory improvements; and animal welfare legislation.

Its vulnerability to so many assaults from so many different quarters stems from the fact that medical education takes place in very large and complex institutions, comprised of at least a school of medicine and a teaching hospital. These settings should more properly be called academic medical centers. Not uncommonly, academic centers contain:

- schools in a variety of health professions (medicine, dentistry, pharmacy, veterinary medicine, public health, nursing, physician assistants, health care administration);
- hospitals, both special (psychiatry, orthopaedic, pediatric) and general (university, VA, county or municipal government, community); and
- a variety of special centers (for cancer, heart disease, diabetes, etc.)

dedicated to research and patient care.

The academic medical center often extends functionally to geographically distant health care institutions such as community hospitals that are intimately affiliated with the medical school and in which students are taught by faculty members in the discharge of patient care responsibilities. The medical faculty:

- teaches students in the preclinical departments of a medical school and the clinical facilities of the teaching hospital;
- conducts scholarly research in the biological and medical sciences, including the training of graduate students in the basic medical sciences and post-doctoral fellows in the clinical sciences;
- provides patient care in the course, or as an unavoidable necessity, of teaching undergraduate and graduate medical students (residents);
- subserves the other traditional roles of an academic faculty within the university; and
- assumes the more recent social responsibilities of an academic faculty to the community in which the institution is located.

The shape and form of the academic medical centers across the length and breadth of this great country display a diversity that, in large measure, accounts for the strength and greatness of American medical education. The general pattern has been modulated in individual institutions by the history and traditions of the universities to which they are attached, and by the mores of the community, state or region in which they are located. While all the 126 operating units share a substantial core of common characteristics and functions, no two are alike and each displays remarkable individuality, characterized by distinctive strengths.

Funding comes to the academic medical center or its components from a bewildering array of sources, each seeking to purchase one of the multiple products and usually at the marginal cost of production. With each purchaser attempting to buy at the margin and none interested in the core functions of the institution, the genesis of fiscal problems becomes easily understandable.

It is no mean task to manage these multiple revenue streams in such a way as to keep the whole institution intact, to maintain reasonable program balance. and to satisfy the accountability demands to sponsors and purchasers. Despite very large cash flows, expenses are equally large and little margin remains for flexibility. Reserves simply do not exist to cover adequately the consequences of unexpected external events, for example, the occasion upon which a faculty member suddenly (and probably temporarily) fails to win renewal of research grant support or when the Health Care Financing Agency (HCFA) arbitrarily decides to base its allowable cost on the experience of a national average of hospitals rather than that of the complex tertiary care institutions that typify an academic medical center.

In the light of this, the AAMC, speaking for its 126 constituent medical schools, views 1980 as a watershed. The future of medical education will be cast in concrete for the rest of this century by the events that occur in Washington and in the capitals of the several states during this year in respect to these crucial programs.

Specific Program Recommendations

The next section of this testimony discusses in greater detail the student assistances, institutional support and special project programs that the Association believes should be enacted into law. The emphasis, as reflected in the discussions within the constituency are on policy, standards, criteria, etc., rather than on specifications or legislative language.

Student Assistance

The needs of medical students for financial assistance vary, from nil through modest to almost total. During the last several years, the inflation of educational costs and their "pass through" in the form of tuition increases, coupled with the increase in living costs in general, have placed more and more students and their families under financial duress. Student debt at graduation--the cumulations of college and medical school loans--is, on the average, high and rapidly rising; it imposes a severe burden on young physicians who still face three to seven years of graduate medical education, during which their incomes will be economically marginal.

Surely there is no entity in American society with a greater interest in or responsibility for providing every qualified citizen the opportunity for a medical education, irrespective of race, creed, color, gender, etc., than the Federal government. The Association views as its highest priority and most urgent recommendation that the Federal government incorporate into law a generous program of scholarships and loans to enable qualified students to undertake the long and arduous task of becoming physicians.

Characteristics to be built into these financial assistance programs deserve careful attention. Perhaps the most important is assured availability. Students should know that once they have gained acceptance to a medical school, assistance will be available until graduation. A number of other criteria may be identified that should be met by a well designed program of assistance to medical students These may be breifly enumerated:

- There should be recognition that student financing of medical education is unique due to: the norm of four years of undergraduate medical education followed by at least three years of graduate medical education for most students (during which stipends range from $13,000 to $16,400) and the curricular demands of undergraduate medical education, which either prohibit or severely limit employment opportunities. Neither teaching assistantships nor fellowships are available for undergraduate medical students.
- As a consequence of their differentiation from other educational programs, administration of medical education financial assistance programs should reside in the health, not education sector of government.

- Financial aid programs should assure access to a medical education for applicants from all income levels.
- To assure most effective and equitable use of financial aid funds, financial aid programs should be need-based and administered by the medical schools. Financial aid officers should be permitted discretion in performing needs analysis.
- There should be separate programs to correct physician maldistribution and to provide student financial aid;

- Financial aid officers should be able to provide students similar financial aid packages for four years provided that the financial circumstances of students and/or their families and/or school costs do not change substantially. Therefore, legislative authorities for student financial aid programs should be five years and funding should be "off budget" to avoid the necessity of annual appropriations.
- Financial aid programs administered by the medical schools should include provision for a fair administrative allowance.
- Loan programs should have reasonable aggregate and annual loan limits.
- A full interest subsidy for loans to undergraduate medical students should be available while they are in school.
- Repayment of loans should be deferred until completion of residency training.
- Loan programs should have options for extended and/or graduated repayment and loan consolidation, all of which should include undergraduate debt.
- There should be a forgiveness option for all loan recipients, guaranteed at

the time the loan is made, for any type of loan, provided that a legal note is signed.

- The National Health Service Corps Scholarship Program and the National Health Service Corps, as well as any future similar program, should be administered by a single agency.
- National Health Service Corps service requirements (and similar future program requirements) should be coordinated with state service requirements.
- That period of required service in such programs should be varied according to practice locations, as an incentive to bring physicians to the most needed practice areas.
- There should be senior premedical preceptorships for the National Health Service Corps and Armed Forces Health Professions Scholarship Programs, to inform students about the nature of both programs.
- Specialty as well as primary care areas should be included in National Health Service Corps type programs.

New and existing student financial aid programs should be evaluated in terms of the extent to which they meet these criteria.

Institutional Support

A variety of cogent arguments may be advanced to justify general Federal support to the institutions engaged in medical education. They add up to the position that the Federal government, as an important beneficiary of the process, both in its own right and as an agent for the general public, should assume its fair share of the unusually costly process. This Senate Subcommittee appears to have shared this conviction in 1971 and at that time requested the Institute of Medicine (IOM) to assess the true costs of medical education and to recommend what would constitute a fair share for the Federal government to underwrite. The report of the carefully crafted IOM study concluded that an appropriate Federal share would be about a third of the educational program costs. The Association found the IOM study well documented and persuasively argued at the time of its publication, and can identify nothing that has subsequently happened to invalidate the arguments or reduce the force of the conclusions.

The clear trends in public policy on this issue since the publication of the IOM Report have been to specify in even greater detail what a school must do to receive a progressively dwindling award. The per capita grant was $2100 in FY 1971, while this years'-- barring rescissions -- will be about $400 in 1971 dollars. Meanwhile educational costs have nearly doubled. As noted earlier, this is the Federal contribution to the support of institutions that, partially in response to Federal programs, have doubled enrollments, mounted (with or without special project grant supports) educational programs in primary care medicine, expanded minority enrollments, and undertaken a host of other public interest activities.

The reality is that the schools are in serious needs of funds. Federal support has become increasingly circumscribed and targeted on a set of Federal needs that are often only marginally, if at all, includable in the core educational content that the schools must provide all students. The crying need of these schools is for flexible funds, usable in their basic education programs as well as for the discharge of their responsibilities as partner of the Federal Government and social problem solver for the general public.

The extremely deep concern expressed by the medical schools at the mere mention of any reduction in or loss of institutional support reflects the fact that for many, even those with very large cash flows, capitation support, small as it is, is their only accessible flexible support. It is virtually the sole source of free money to meet unexpected emergencies and contingencies; to reimburse faculty members who devote time and effort to developing new curricular offerings, new demonstration programs, new pedagogic materials; to finance the front-end costs of applying for Federal special project funds; etc., etc. The worth of these monies is far greater than would appear from their actual magnitude. Most medical school deans view capitation support as *the* most valuable money at their disposal.

There is a prevalent misperception that student financial assistance funds are essentially fungible with flexible institutional support: schools can secure the latter by raising tuition, an option made viable by the fact that students have access to loans or scholarships. This argument has very limited validity. Private schools have virtually unlimited freedom to increase tuition at whatever frequency and to whatever extent they desire. Tuitions in many private schools are already staggering. The result is that the social/economic/cultural/ethnic mix of the student body becomes a less representative and more elitist crosssection of America. But for most public schools tuition increases are not a viable option. The process itself is complex, time consuming and cumbersome, often requiring action by a Governor, a Legislature (which may meet only biannually), a Board of Regents or a State Commission on Higher Education. The result of an increase is variable: in some states, tuition is returned to the State Treasury, deposited either in a general or a dedicated (to, for instance, retirement of construction indebtedness) account; in others, the increased revenue from tuition can and often will be offset by an equivalent decline in appropriated funds. These realities have persuaded the Association that expanded student assistance programs, critically needed by students, are not a viable mechanism to provide flexible support to institutions.

Accordingly, the Association strongly advocated the award of flexible institutional support funds to medical schools as the primary instrument of Federal support of medical education. While still convinced that Federal support of a third of the cost of each student's education is appropriate, a somewhat reduced amount would be temporarily acceptable in view of the exigencies of the times.

While reluctantly recognizing the inevitability of conditions for participation, the Association felt that any such condition must meet two criteria to be acceptable: that it be compatible with and not violative of, the essential nature of the institution requesting support; and, that it reflect sound public policy. The first criterion would require that the condition imposed be germane to the purposes and function of the institution as historically and legally constituted, fall within the scope of the activities over which the institution has control, respect the institution's academic traditions, and constitute a true flexible institutional subsidy, not simply cost---or less than cost---reimbursement to carry out a Federally mandated specific task. For instance, medical schools have limited powers to influence specialty and geographic distribution of physicians; to demand of them what is not feasible would be ineffective and unfair. The second criterion would guarantee that the schools be required to accept only conditions leading to outcomes generally recognized as highly desirable national goals. The expansion of undergraduate medical school enrollments to avert a critical shortage of physicians was subject to almost unanimous agreement throughout the country a decade ago, and thus reflected sound public policy at that time. But events have so greatly changed the present realities that further enrollment increases may lead to physician oversupply and an enrollment decrease may be needed in the not too distant future.

Finally, it seems important to register one additional demurrer related to the increasing specificity of the terms which schools must accept as preconditions for receiving Federal institutional support. This protest arises not out of any desire to evade work or to get a free ride, but out of a deep conviction that this government posture is self-defeating, even though it may give the appearance of responsible stewardship of public funds. The schools have a capacity to do far more than narrowly conceived tasks that have matured to the stage of being reducible to legislative language. They represent a perennial resource of imaginative ideas for the resolution of societal problems. Their faculties are usually far ahead of other segments of society in recognizing problems and in taking cuts at their solution. What the government should seek, if it really wants to exploit this treasure of talent, is a way to keep the attention of academic faculty focused on as wide as possible a spectrum of both mature and inchoate problems.

Special Project Grant Programs

Special project grant programs complement in very important ways the other mechanisms for Federal assistance to medical education. Under this rubric, solutions to specific societal problems can be sought through what are really cost reimbursement contracts between the government and institutions possessed of the resources to carry out the project.

The great virtue of special project grant programs is that they can propose an extremely broad range of objectives and are ideal for exploiting to the maximum the rich diversity represented among the schools. Moreover, these awards seldom really reimburse full costs. Absent another mechanism of Federal support such as capitation, schools must subsidize projects from other limited resources

Comments on Specific Legislative Proposals

The Association has reviewed these bills in the light of the broad policy positions that it has adopted and they are discussed under the major program concepts: student assistance, institutional support, special projects, construction, and foreign medical graduates.

Student Assistance Provision of S.2144 and S.2375

Prior to 1960 the cost of medical education to the student was not perceived as a problem of national significance. At that time, tuition and other educational expenses were relatively low and thus access to health professional careers was possible for most students from moderately affluent circumstances through reliance on family resources and private loans. However, in the early 1960s, three major forces that altered this situation began to exert their influence.

Of the foremost importance was the sharp escalation in the cost of medical education which paralleled all the other health care costs in the United States. The second was an increased effort by the medical schools to broaden the socioeconomic base of the population of medical students. Finally, the realization arose that the nation was facing a serious shortage in the supply of physicians and other health professionals. In response the Federal government assumed a leading role in the development of student assistance programs designed: to encourage careers in the health professions; to assure students from all economic circumstances access to medical or other health professions schools; and to allow young physicians the freedom to practice in the specialty and geographic area of their choice.

However, the passage of P.L. 94-484 in 1976 made it clear that national priorities had changed once again -- the problems of the geographic and specialty maldistribution of physicians were perceived as paramount, and the expansion in the numbers of health professionals was no longer considered to be a highly desirable goal. Thus, the nature of Federal financial assistance changed; the student assistance programs outlined in P.L. 94-484 are largely scholarship and loan programs tied to national service committments. In an evaluation of these programs, the Report of the AAMC Task Force on Student Financing found that "... this trend has had a major and often disturbing impact on students whose personal career goals are not compatible with the constraints imposed by Federal financial assistance but who, in the face of rising costs and diminishing private resources, are otherwise unable to finance a medical education." The report also concluded that the implementation of the student assistance elements of P.L. 94-484, "suggests an unsatisfactory resolution to the national societal goals of equal access to education and equal access to health care services."

The Association is pleased to note that both of the proposals that are before this Subcommittee indicate cognizance of the fact that the assistance programs currently extant have deficiencies which require that they be seriously reconsidered and substantially revised. Both bills attempt, albeit through different means, to deal simultaneously with two goals: alleviating the problems of geographic and specialty maldistribution; and, permitting access to health professional careers to all students on an equitable basis. These goals are entirely consistent with the beliefs of the Association and its member institutions.

The AAMC, after reviewing the student assistance elements and concepts embodied in both S.2144 and S.2375, believes that there are advantages in both proposals, but remains firmly convinced that any student assistance structure must be designed to provide reasonable and equitable choices to all students.

Analysis of the two proposals indicate that both offer a mixed portfolio of assistance options designed to serve the twin goals of improved distribution and equitable access to health professional careers. It would probably be most useful to discuss these programs and their potential ramifications individually within this framework.

Student Loan Programs

Health Education Assistance Loans (HEAL) S.2375 proposes to retain, with important modifications, the HEAL program established under Public Law 94-484. This program has proven to be unpopular with borrowers and lenders alike. For the student, restrictive terms limit access to the loans and allowable uses for the borrowed funds, but the biggest deterrent is the heavy repayment burden --- a student borrowing $32,000 is liable to repay a total of $148,709 over a 15-year repayment period. For the lender, the 12 percent interest ceiling is prohibitively low under market conditions experienced in the recent past. To date, only about $23 million has been borrowed under this program approximately $5 million of which has been loaned to medical students.

The Association is pleased to note that S.2375 makes an effort to modify the program embodied in the current law by:

- expanding the use of HEAL funds to include reasonable living expenses.
- eliminating the stipulation that no more than 50 percent of each school's students can receive HEAL loans.
- removing the provisions that students cannot be eligible for both HEAL and GSL loans in the same academic year.
- liberalizing the program's deferral provisions.
- providing for less burdensome repayment terms by: (1) requiring that the borrower be offered a graduated repayment option with larger payments due later in the repayment period; and (2) stipulating that the borrower be offered, at the option of the lender, "a variable interest option" at the time the loan is made.

From the viewpoint of the lender the program is made more attractive by the elimination of the 12% interest ceiling.

The presumed rationale for retaining this program is to provide a reasonable form of assistance to students that would not include a service obligation. While the Association believes that this program has been and would be useful to a student only as a last resort, it feels that the proposed modifications have gone a long way towards eliminating the problems in the specifications presently embodied in P.L. 94-484. The Association would recommend that NHSC and Armed Forces scholarship recipients not be excluded from receiving HEAL loans, as proposed in S.2375. These individuals may need additional funds to meet family responsibilities.

Federally Guaranteed Loan Program. In contrast, S.2144 eliminates the HEAL program, and establishes a two-pronged alternate, one aspect of which would provide loans for all students. As delineated under S.2144, this program would:

- Provide students with a Federally guaranteed loan with an aggregate limit of $80,000 available at market interest rates not to exceed 15 percent.
- Defer repayment of the principal and interest until completion of three years of internship and residency training, service in the National Health Service Corps or service in the Armed Forces.

While this proposal also eliminates many of the problems in the current HEAL program, it still retains burdensome repayment terms.

Assistance for Exceptionally Needy Students

Exceptional Financial Need Scholarships (EFN). Under P.L. 94-484, only first-year students in exceptional financial need -- those students with virtually no financial resources -- qualify for this program; recipients receive tuition, fees, and a living stipend of approximately $5,500 per year, and incur no service obligation. This program has been praised in concept, but its implementation has drawn criticism. The 1978 report of the AAMC Task Force on Student

Financing pointed out that: the definition of "exceptional financial need" as zero financial resources is unreasonably restrictive; scholarship support for only one year is inadequate and should be expanded to two years; and appropriations for the program have been inadequate.

S.2144 does not include this program nor any other designed to assist the access of the exceptionally needy student to health professional careers. The program has been retained, in modified form, in S.2375; the amount of the scholarship would be limited to the lesser of tuition and fees plus $2,500 or $5,000, and scholarships would have to be distributed to schools based on the proportionate enrollment of first-year students in exceptional financial need. The purpose of these alterations is presumably to reduce the amount of the individual awards in order to make a greater number of scholarships available.

It is the Association's view that the program meets an important social need and that the changes proposed in S.2375 assist in achieving the objectives of the program. However, modification of the definition of exceptional financial need to include more needy students and expansion of the period of support to two years would strengthen its viability and effectiveness. It is important to note that under the present definition of exception financial need, still only approximately 700 students in an entering class of approximately 17,000 (roughly 4.0%) students would qualify for this program.

Assistance for Needy Students

Service Contingent Loan Program. S.2375 proposes to amend Title VII of the Public Health Service Act to eliminate the Health Professions Student Loan (HPSL) Program and to establish a new service contingent, campus-based loan program for which all health profession students would be eligible. The Government's capital and income from the dissolution of the HPSL program would be used as one of the several elements that would help finance the new loan program. Presumably, this program is intended to provide a form of assistance that would meet the needs of a greater number of students than did HPSL and assure the availability of an adequate number of health professionals for national service.

The Association believes that this program could represent a viable and fair alternative for the needy student, with two possible reservations.

- Presumably, the fundamental purposes of the program is to create a reserve pool of physicians to complement, when necessary, the NHSC in providing more family practitioners and primary care physicians in shortage areas. Unless a need for non-primary care physicians on a substantial scale is forseen, young physicians in primary care fields will be more vulnerable to a call to service than their colleagues in other specialties. Thus physicians whose graduate medical education was in non-primary care specialties could be assured of a low interest loan with probably a small risk of having to fulfill a national service commitment.
- The bill does not provide a deadline by which the Secretary must notify students whether they have been selected for national service and where they will be required to serve. Due to the lack of such deadlines, students serving under the National Health Service Corps Scholarship Program have experienced serious difficulties that have caused unnecessary havoc in their personal and professional plans. The AAMC urges that the Secretary be mandated to establish by regulation strict notification deadlines for the service contingent loan program.

Federally Guaranteed Loan Program for Needy Students. S.2144 also proposes to eliminate the Health Professions Student Loan (HPSL) Program and to replace it with a Federally guaranteed loan program for needy students using private loan markets. Under this program students would be able to borrow up to $20,000 per year at a Federally subsidized interest rate of 7 percent during medical school and specified periods of service perceived to be in the national interest. Moreover, repayment of the principal and interest would be deferred until completion of three years of residency training, internship and service in the NHSC or service in the Armed Forces. It appears to the AAMC that such a program could constitute a viable and reasonable alternative for the needy student.

However, S.2144 proposes that the Federal Government's capital and income from the dissolution of the HPSL program be utilized to establish a new Student Loan Forgiveness Fund, to provide complete or partial loan forgiveness for: death or permanent disability; unsuccessful first year students; and service in shortage areas. It is doubtful that the funds recaptured would be adequate for these purposes.

Elimination of the Health Professions Student Loan (HPSL) Program. While both of the programs in the two bills designed to replace the HPSL Program clearly have merit, the Association is puzzled by the decisions to eliminate this program in light of its success from the viewpoint of both the students and the schools. For academic years 1977-1978 and 1978-1979 respectively, awards to 10,926 and 9,808 medical students were made under this program. The 1978 Report of the AAMC Task Force on Student Financing found that the HPSL program was an important factor in minimizing the debt burden on economically disadvantaged students and concluded that:

> "The HPSL program will help insure that the consequences of the apparent Federal policy of having medical students pay for a larger share of their educational costs does not fall disproportionately upon the economically disadvantaged student, therefore effectively further limiting access to medical school for these students."

The Association believes that leaving the revolving HPSL funds in the schools for continuing need-based loans to students would create a permanent revolving fund in the schools that would constitute a sound means, both from an economic and a public policy perspective, of financing assistance to students.

National Health Service Corps (NHSC) Scholarship Program.

Both bills propose modifications in the National Health Service Corps Scholarship Program.

S.2144 proposes to phase down the NHSC Scholarship Program over a two year period to one third of its FY 1980 level. The decrease in funds for the program would be offset by a new state, service-conditional scholarship program modeled on the NHSC. The apparent purpose of this proposal is to reduce the dependence on the NHSC as a form of student assistance, and to assist the states in assuming more responsibility for the solution of health manpower shortages within their own boundaries.

While the Association believes that these are desirable goals, it seriously questions the feasibility of this program. S.2144 would establish a program of Federal grants to the states---both basic and matching grants---to fund service scholarships to individuals willing to serve in shortage areas. The states would be required to assume the responsibility for funding the salaries of the scholarship recipients entering the payback period at a level "not less than the comparable salary of entry-level individuals employed by the United States who possess a similar educational background." The Association believes that the economic burden this program would place on the states could pose a very real problem, the ramifications of which have not been adequately explored. Before setting such a program into place, and phasing down the NHSC Scholarship Program it is essential thatthere be concrete evidence it would be viable on a state level. The Association is aware of no evidence that the states would welcome the burden this program would put upon them. Opinions have been expressed that the states have already been contributing more than their fair share to the support of medical and health education. Indeed, it is our understanding that the Southern Regional Education Board is planning to convene a conference in May or June of this year to explore this issue.

S.2375, in contrast, proposes a more vigorous continuation of the Scholarship Program with a number of modifications designed: to discourage use of the program as a form of student assistance, and, to encourage scholarship recipients to remain in shortage areas after the completion of their service obligation. At this time, the Association believes that the program proposed in S.2375 would be more feasible than that advanced in S.2144.

National Health Service Corps Private Practice Option. During a period of seriously contracting resources, the AAMC has been deeply concerned about the possibility that excessive funding for the NHSC program could seriously compromise the viability of other important programs. Both bills make an effort to encourage the expanded use of the private practice option under the NHSC in order to reduce the costs of the Corps---a goal which the AAMC supports. In S.2144, this is limited to eliminating the income equivalence test and permitting individuals receiving scholarships under the new state service program to enter private clinical practice in shortage areas in lieu of payback through state service. However, S.2375 goes considerably further in establishing incentives to increase the use of the private practice option by: eliminating the income equivalence test; requiring that, prior to placing a Federally paid physician in a shortage area, the Department of Health and Human Resources make the determination that an NHSC physician is not available under this option; requiring the Secretary to provide each individual participating in this program with technical assistance "to assist such individual in fulfilling his agreement"; and, permitting the Secretary to pay each individual, up to $10,000 in the first-year; $7,500 in the second year; $5,000 in the third year; and, $2,500 in the fourth year of obligated service, or the difference between the individual's income and what it would be as a member of the Corps, whichever is less plus the cost of the individual's malpractice insurance.

In comparison, these latter modifications might prove more successful than the limited changes advanced by S.2144.

Health Personnel Data

The Association would like to suggest some technical changes in Section 708 of S.2375: On page 5, line 33 and on page 7, line 14 the word "Race" should be added, to help determine minority participation in both specialty and geographic distribution.

Institutional Support Provisions of S.2144 and S.2375

Both S.2144 and S.2375 implicitly recognize the importance of institutional support to the medical schools by incorporating awards for it into the proposed legislation. The AAMC and its member institutions hope that the Subcommittee will endorse the concept by retaining it in the bill that is reported to the full Committee.

General Comments.

The approach of these two Bills to the method for supporting institutions differs sharply. S.2375 would compute the size of the award to each school as proportional to a basic amount that could increase or decrease, depending on the response of the institution to national goals established by the Congress. S.2144, on the other hand, would limit eligibility to only those schools that successfully competed for one of the special project grant programs outlined in the Bill and that, in addition, met several other requirements; the amount of the institutional support award would be 20% of the amount of special project grant funds that the institution received, i.e., a "surgrant" on the special project awards. The Association prefers the approach embodied in S.2375 for several reasons: all schools would be eligible; schools could probably increase their awards substantially by meeting stated national objectives; institution would be supported for both what they had already done and are currently doing to meet national needs; schools would be offered financial incentives to incorporate additional national interest activities into their programs; and schools would be able to select from a range of incentives broader than primary care and ambulatory medicine, reflecting more fully the diversified strengths of the 126 operating U.S. medical schools.

S.2144 also implicitly recognizes the value of diversity, but not to the same degree. Rather, it defines the national interest narrowly around the concepts of ambulatory medicine and the provision of health services to the remote areas of the country; it does not offer inducements for institutions with significant strengths in other areas to join in a partnership with government. Moreover, as noted above, not all schools could expect to receive this institutional "surgrant," since not all schools would be likely to be recipients of special project grants. In FY 1976 and FY 1979, twenty-four percent and seventeen percent respectively of the medical schools received no special project money, even though virtually all schools were engaged, often intensively and without Federal funding, in types of activity supportable under the Special Project Grant authority. Furthermore, receipt of a special project grant would not guarantee receipt of a "surgrant." Of the 80 institutions that responded to a questionnaire sent to all deans in late 1979, only 64 (71 percent) of the respondents could meet the additional eligibility requirements for a "surgrant." Under these circumstances, the government would not easily accomplish the purposes of its special project grant programs, since these awards generally fail to reimburse fully the cost of the project, and the schools would have no other source of funds to make up the deficit, unless they were willing themselves to subsidize the government or to pass that responsibility on to their students through tuition increases. More institutions simply could not afford to undertake special projects.

The aggregate authorization for special project awards (including the "surgrants" for institutional support) in S.2144 approximates $295 million --- an amount for which not only medical schools but all other schools of the health professions would compete. If the medical schools were to receive the same percentage (37%)of the FY 1981 authorization as they did in FY 1979, their total capture of special project funds under S.2144 would be $109 million, 20% of which or $22 million would be for institutional support. This would average about $340 per student. Put another way, for the amount of the institutional support to equal the FY 1980 capitation appropriation --- $50 million --- would require an appropriation --- not an authorization --- of at least $250 million, an unlikely eventuality when the total authorization as proposed in S.2144 is $295 million.

Specific Considerations.

In designing the next health manpower Bill, the AAMC recommends that Subcommittee take the stated positions on the following issues related to institutional support.

Institutional Eligibility: All medical schools should be given an opportunity to qualify for an institutional support grant and eligibility should not be limited to successful applicants in competitive grant programs, as is proposed in S.2144.

Academic Freedom: The curriculum of a college or university is fundamentally the responsibility of its faculty. Incentive grants to support curricular innovations of special interest to the Congress are appropriate, but requiring curricular changes as a precondition for receiving institutional support is not. The Subcommittee is urged to respect and support academic freedom, by avoiding any suggestion of Federally dictated curriculum requirements.

Tuition Stabilization: S.2144, as one of the alternative requirements for receiving institutional support, would place a fixed percentage limit on increases. If a limitation is really deemed prudent, the new legislation should continue the more flexible standard set in Section 711 of the PHS Act, rather than adopt the rigid provision of S.2144. With inflation accelerating, institutions should not be penalized for passing through their unavoidable cost increases. The estimated increase in energy costs alone for the Harvard Medical School next year is $2.0 million.

Distribution of Institutional Support Among Medical Schools: Medical schools have built the current levels of institutional support into their operating bases, and an abrupt and radical change in the pattern of distribution among the 126 schools would be upsetting. S.2375 would base the distribution of institutional support on the number of students at the institution, and would thus distribute support to schools that qualify in roughly similar fashion as in the past. Under S.2144, the pattern of distribution would probably be quite different. The AAMC would recommend that disruption should be avoided to the extent possible.

Eligibility Requirements for Institutional Support: The incentives and disincentives in S.2375 and the eligibility requirements for the surgrant in S.2144 are quite similar. Since many institutions are already engaged in activities perceived in these proposals to be in the national interest, the Subcommittee should adopt the approach encompassed in S.2375 rather than to require schools first to compete successfully for a special project grant and then to meet a series of special conditions in order to qualify for an institutional support "surgrant."

The Concept of National Interest: By the nature of its own process of concensus development, Congress tends to address the immediate future, to identify desirable goals, and then to encourage a uniform national response to meet these goals. The medical schools of the country also have a concept of what constitutes the national interest; their views tend to be more long range and more diverse than legislation is likely to be. The 126 medical schools of this country are a national resource, and the maintenance of their diversity is in itself in the national interest, if the probability of discovering productive and innovative responses to the changing medical and health needs of the American people is to be maximized. Diversity is diminished by a requirement that all schools place heavy emphasis on primary care and ambulatory medicine in underserved and remote areas. While S.2375 goes further than S.2144 in encouraging individuality among the medical schools, the Subcommittee should expand the list of incentives so as to take advantage of the whole range of strengths of all institutions.

Enrollment limits. A provision should be included to waive the penalty for enrollment increases in excess of 2% in the case of developing schools as well as for schools that increase their enrollment in order to accept more minority and women students.

Conclusion

Of the two Bills that currently propose institutional support, the Association strongly favors the adoption of the National Incentive Priority Grant Program of S.2375, with the modifications suggested. This Bill would provide more dependable institutional support, reward schools for past accomplishments, and preserve the diversity of U.S. medical schools. S.2144, on the other hand, would: provide less total institutional support than is presently awarded under the capitation grant program; distribute the funds differently than under current law, with many schools receiving no support at all; apply more restrictive conditions than P.L. 94-484; and force schools to compete with one another for the limited special project grant dollars. Under the latter Bill, the most significant loser would be the "national good." The medical schools would have little reason to respond to national goals and the federal government would lose whatever leverage it had on the schools to encourage attainment of those goals.

Special Project Grant Programs

The special project grant sections of the two bills display considerable similarity. Differences of note include the following:

- The authorization ceilings are consistently higher in S.2144, attributable in part to the fact that institutional support "surgrant" funds are included.
- S.2144 supports the current law by not permitting hospitals to apply for primary care grants in internal medicine and pediatrics. S.2375 permits both hospitals and medical schools to receive these grants. The Association would recommend that the provisions of S.2375 be incorporated into any new legislation.
- S.2144 does not provide funds for the development of programs to encourage the entrance of women into health careers, a goal which the AAMC would recommend that the Congress support.

While the catalog of special projects listed in each Bill reflects a quite comprehensive view of activities currently in the public interest, the Association would suggest the possibility of including several additional items in the Special Project Grant Program:

- The development of a special training program for women and minorities interested in careers in academic medicine.
- A training program for third year residents in internal medicine or pediatrics on practice management, with an emphasis on cost containment in private practice.
- The creation of a program or series of activities to encourage students and residents to consider academic research careers.

- The development of programs to satisfy the needs of Physicians in rural or underserved areas for interaction with faculties of academic medical centers and for current information on scientific advances in selected specialty areas.

As is probably obvious from the previous comments regarding institutional support, the Association has a strong preference for the legislative design utilized in S.2375, under which special projects and institutional support are totally independent of one another. Their coupling in S.2144 would arbitrarily deny institutional support to institutions that did not successfully compete for special project grants, when many of those institutions carry out ---vigorously and without Federal reimbursement --- the identical types of activity for which special projects are given. Moreover, the strategy embodied in S.2144 would often compromise the ability of the government to achieve the objectives of the special project grant funds, since many schools would be discouraged from participating by virtue of the small reward for an effort both relatively large in size and peripheral to the central mission of the schools.

The authorization ceilings recommended in S.2375 for Family Medicine, Area Health Education Centers, and Training in Primary Care Internal Medicine and Pediatrics seem inadequate. While the Association is sensitive to the desire of the Congress to hold down federal spending wherever possible, reduction of the authorization ceilings of programs that have been successful in ameliorating the geographic and specialty maldistribution of physicians is unwise. If the aggregate special project authorization ceiling cannot be increased, the Association would much prefer reductions in authorizations for programs whose success is not yet evident.

Institutions in Financial Distress

Both Bills authorize support for institutions in financial distress but with different mechanisms. S.2144 proposes two types of financial distress grants, one short-term and the other long-term. The short-term proposal is similar to the financial distress grant in S.2375, making funds available to institutions whose financial status threatens their operation, or that need assistance in meeting accreditation requirements. The long-term version of the financial distress grant authority in S.2144 is available to all institutions,but S.2375 contains instead a cooperative agreement authority designed specifically for minority and other "national priority" institutions. While the Association agrees that this country cannot afford to let its minority institutions become insolvent, there might be circumstances which other institutions would also benefit from a cooperative agreement, or might even require this for survival. Thus, it is recommended that both forms of financial distress grants available in principle to all institutions. The Association opposes any requirements for a school to obtain state funding in order to be eligible for the financial distress program. Current law and Section 711 of S.2144 require "operational reforms ... including the securing of increased financial support from State or local governmental units or the increasing tuition," while Section 712 of S.2144 makes increased state or local support an absolute requirement. That virtually all of the institutions in chronic financial distress are private sector minority institutions is well-known. Since these institutions serve a national constituency, state governments are loathe to come to their assistance,as they would for a state-controlled institution. The institutions in distress have no control over their access to state support, and it is unfair to place this requirement on them.

Special Project Provisions of S.2375

The Association has very quickly reviewed Title II of S.2375 and finds it basically unobjectionable. In designing the special project component of the manpower legislation, that AAMC would urge the members of the Subcommittee to concentrate the bulk of a very limited authorization on those programs that have been successful in addressing national problems and spread the rest of the available funds across a range of activities that would attract the most attention from 126 very diverse institutions. It would be hoped that such an approach would entice the participation of a large number of medical schools.

Construction Provisions of S.2144 and S.2375

General Provisions

P.L.94-484 extended: the existing grant program of assistance for construction and renovation of teaching facilities; and authorized a new program to assist the construction of ambulatory primary care teaching facilities, designed to achieve the dual goal of expanding enrollment and encouraging the teaching of primary care. In recognition of the growing perception that expansion in the number of health professionals is no longer a desirable goal, both S.2144 and S.2375 propose substantial revisions in program comstruction authorities.

S.2144 eliminates all authority for construction, except for new schools, and provides support, mainly through interest subsidies, for the renovation, modernization and conversion of existing facilities for use as ambulatory primary care teaching facilities, as well as for other teaching and research activities. In contrast, S.2375 reauthorizes the construction and renovation grant program established by P.L. 94-484 in modified form, but on a drastically reduced scale. It also excludes construction or renovation in hospitals or out-patient facilities from eligibility under this program.

The Association questions the wisdom of completely eliminating construction grant authority for existing schools. Such a plan is highly undesirable; clearly, many existing educational "plants" are in need of replacement and the Association also has reservations concerning the use of interest subsidies to fund construction programs as outlined in S.2144, and sees much merit in tendering direct grants instead. Of greatest concern are the low authorization levels proposed in both bills. Thus, the Association recommends that all existing authorities be retained and that the authorization levels be substantially increased.

Enrollment Increase Requirements Under Past Awards

The Health Educational Facilities Construction Program authorized under Title VII Part B of the Public Health Service Act requires applicant institutions to make a one-time increase in first year enrollments as a condition for receiving an award. Many applicants volunteered even greater increases, both in the hope that this action would increase the attractiveness of the application and out of a desire to make a large contribution to the solution of what was generally perceived as a critical national problem --- a shortage of physicians.

A number of new facilities, constructed in part with Federal funds, will be completed on schedules that will require the schools that built them to expand enrollments in either academic year 1980-81 or 1981-82.

In the aggregate, the production capacity of the U.S. medical education "plant" has been more than doubled since Federally assisted medical school construction authorized by the 1963 statute began. The lag time between entry into medical school and into practice is long, and the country has yet to feel the full impact of this expansion in capacity. But looked at realistically, it is hard not to recognize that the current production rate will at the very least, more than meet the most generous estimates of physician need. Thus, nothing would seem less in the public interest than further expansion of enrollment.. - Yet a statutory mandate exists that would do precisely that.

Both S.2144 and S.2375 recognize that sound public policy requires modification of this statutory mandate; the Association concurs. The bills provide different solutions. S.2144 provides that the Secretary shall "unilaterally release" such schools from their obligation to fulfill this requirement; the language in S.2375 is less specific --- it provides that the Secretary *may reduce or eliminate* this requirement after consultation with the National Advisory Council on Health Personnel. The Association believes that the language embodied in S.2144 is more appropriate than that specified in S.2375.

Foreign Medical Graduates (FMG) Provisions in S.2378

S.2378 proposes major changes in legislation related to foreign medical graduates (FMG's) in, or coming into, the United States for graduate medical education under the student exchange (J-Visa) provisions of the Immigration and Nationality Act.

- The permissable duration of the training program would be extended to match the requirements for establishing eligibility to sit for specialty board examinations.
- The requirement to pass the Visa Qualifying Examination (VQE) as a condition for receiving a J-Visa would be waivable until December 31, 1985 under circumstances in which its imposition would substantially disrupt the health and medical services provided by the hospitals

in which the graduate medical education of these physicians took or, was to take, place.

- The definition of a health manpower shortage area would be amended to include hospitals, more than 25% of the resident staff of which were FMG's. This statutory redefinition would have the effect of making such hospitals appropriate sites for the assignment of physicians who had held National Health Service Corps (NHSC) scholarships while in medical school.
- Physicians who had held NHSC scholarships would be permitted to credit the time spent in these hospitals in the status of graduate medical education students (interns and residents) toward the service payback obligation in their scholarship agreements.

Extension of Training Period Permitted Under the J-Visa

Of the FMG proposals before the Subcommittee, the one to permit an extension of the period of training has been the most widely discussed and is the least controversial. Currently, FMG's who have passed the VQE may come to the United States for graduate medical education for a period of two years, with extension for a third year contingent upon approval from the visitor's home government. This arrangement does not give resident physicians adequate time to meet eligibility requirements of many of the medical specialty certifying boards of the American Boards of the Medical Specialties (ABMS), requirements that may be assumed to reflect the necessary period of training for a designated specialty. Under the current law, the VQE and language requirements assure the competence of the alien graduate medical education students. Thus, there would seem to be little reason to limit the participation of such qualified aliens in U.S. education programs, provided of course that they could be accommodated locally. This country has had a long tradition of welcoming exchange students and U.S. educational institutions point with pride to the achievements of their alumni who attain distinction in their country of origin. If graduate medical education programs accept alien physicians, there is little reason to truncate tenure prematurely, i.e., before the training program has been completed. The only real objection is that the longer training period gives the exchange visitor a longer exposure to the "hazard" of acquiring an American spouse, and, therefore, American citizenship. By and large however, extension is in the best interest of the individual, the program and the U.S.; on that basis the Association supports the proposal to amend Section 212(j)(1)(D) as drafted in S.2375.

Extension of VQE Waiver Until December 31, 1985[5]

One of the most significant changes to the INA that occurred with the passage of P.L. 94-484 was the institution of a requirement that J-Visa holders would have to pass the VQE rather than the ECFMG examination. The purpose of this modification by the Congress in 1976 was to raise the educational achievement standards for FMG entry into the U.S. for graduate medical education, and thereby to protect the American public from contact with inadequately educated physicians serving as hospital residents. The current statute requires that, as of January 1, 1981, all FMG's coming to the U.S. for training will have passed the VQE; until then, institutions can file for a waiver of this VQE requirement, on the ground that there would be "substantial disruption" of medical service if FMG's on the staff of an institution were required to have passed this examination.

The AAMC recognizes that a few hospitals in this country, particularly in SMSA's such as New York City are faced with severe problems in recruiting USMG's for their residency programs. Nonetheless, the issue is no different today than it was when P.L.94-484 was passed in July 1976. If "substantial disruption" waivers are continually granted, these hospitals which have had four years to correct their deficiencies will postpone confronting the real problem --- the quality of the graduate medical education offered and the consequent inability of the program to attract graduates of U.S. medical schools. The AAMC does not take pleasure in appearing to be unsympathetic to the needs of these distressed hospitals. But it is equally distressed by the fact that a substantial segment of the least advantaged American citizens who live in the affected areas and who depend on these hospitals almost exclusively for their medical care, must rely on physicians who cannot pass an examination so designed that 95% of U.S. medical graduates would be expected to pass. Current practices --- apparently little different than those prevailing before the enactment of P.L. 94-484 --- are not a socially acceptable, let alone an ideal solution to even the medical care aspect of this problem.

The Associaion must, however, regard this as an education issue. In this context, it is persuaded that, if the directors of those graduate medical education programs and the medical schools with which they are affiliated were forced to focus attention on the quality of the training programs, the dependence of these programs on FMGs would rapidly diminish. Some graduate education programs in the same institutions that request waivers for others of their programs have been strengthened and now attract graduates of United States medical schools or qualified foreign medical graduates.

It is also important to recognize the well nigh heroic dedication of the staffs of these hospitals to meeting the crushing workload that descends upon their institutions from the abandoned peoples of poverty devastated inner city slums. This load will not go away and devices must be found to handle it. To a large extent, the problem is economic. There can be little doubt that resident physicians are traditionally willing, even eager, to put in long hours in exchange for a quality education experience to make the educational experience meaningful and attractive to qualified medical graduates and to provide adequate supervision of the medical services provided in the institution, additional numbers of attending staff are necessary and this would cost money.

The Association and its members can contribute to the solution of the educational problems that are involved in this area, but that contribution provides too narrow a perspective on an immense social and economic problem. The Subcommittee urged to examine this issue in all of its dimensions and to ponder the ramifications of this apparently minor amendment to extend the period during which the VQE requirement could be waived. In the opinion of the Association, such an action is not in the best interest of education, of medicine or of the urban poor. The latter deserve, and ought to be provided, a better solution than is contemplated by this provision. We are faced with a political crisis. Only a totally inadequate and inappropriate educational solution is offered.

Designation of Selected Hospitals as Health Manpower Shortage Areas and Fulfillment of NHSC Obligation Through Participation in Designated Residency Training Programs.

S.2378 proposed that hospitals more than 25% of whose resident staff is composed of FMGs be designated as health manpower shortage areas (as defined in Section 332 of the Public Health Service Act). As such, these institutions would then become eligible to have NHSC scholarship recipients assigned to them in fulfillment of the volunteer's service obligation. Additionally S.2375 specifies that an individual who chose to serve as a resident in a hospital so designated could credit the period of residency training toward the satisfaction of the individual's NHSC obligation.

The AAMC supports defining hospitals with a significant dependence on FMGs as health manpower shortage areas for the purpose of having NHSC volunteers assigned to them. The Association must oppose, however, the award of service pay-back credit to residents for the period of graduate medical education received in these hospitals. A review of the legislative history of the National Health Service Corps indicates that this program was designed to provide fully trained and qualified physicians to deliver medical care to the underserved populations of this country. Residents are not fully trained; in fact, they are trainees. To allow them to accrue pay-back credit while still in student status contravenes the original, and still valid, intent of the Congress. Section 752b5 (A) of the PHS Act very clearly states: "No such period of intership, residency or other advanced clinical training shall be counted toward satisfying a period of obligated service" for NHSC.

The AAMC is well aware of the issues surrounding the INA-related provisions included in S.2375. The Association and its constituents support the extension of the period of training under the J-visa as redounding to the benefit of medical education, foreign medical graduates, international health and international amity. It also supports the designation of certain hospitals as health manpower shortage areas. In the view of the AAMC, however, Congressional adoption of the other two proposals would be a grevious setback for the long standing efforts of this country's medical education enterprise to improve graduate medical education and the care delivered to the underserved and disadvantaged populations of this nation. On that basis, the AAMC supports neither extending the VQE waiver beyond December 31, 1980, as provided for in current law, or permitting NHSC scholarship recipients to repay their NRMA obligation by serving in residency positions in hospitals more than 25 percent of whose resident staffs are comprised of FMG's.

Overall Summary and Conclusions

The Senate has opened debate on three Bills concerned with health manpower. The AAMC has outlined to the Subcommittee the broad policy perspective which it endorses on Federal financial assistance to medical students and to medical education and has evaluated the pending proposals in the light of this perspective. The Association stands prepared to provide any further assistance to the Subcommittee that is desired.

But in closing, the point should

finally emerges through the long process of Congressional debate is of critical significance to a set of institutions whose health and well being is of enormous importance to the nation and whose vitality is being sapped by a series of unprecedented assaults. During the middle half of the twentieth century, American medical education went from the depths to a pinnacle of outstanding achievement. In the course of this meteoric ascent, the general public has reaped a rich harvest of benefit. Moreover, every evidence suggests that the best is yet to come, that we stand at the threshold of another great leap into new achievement.

The action taken by the Congress on these bills will have a profound impact on the future of medical education and, through it, on the future health and well being of our people. If the Congress acts wisely and generously, a Periclean age in medical education will continue.

Senator **Metzenbaum**. Thank you, Dr. Stemmler.

Dr. Charles Moore, president of Kirksville College of Osteopathic Medicine.

Dr. **Moore**. Mr. Chairman, I am Dr. Charles Moore, president-elect of the American Association of Colleges of Osteopathic Medicine, and president of Kirksville College of Osteopathic Medicine.

We have submitted longer testimony for the record, and in the interest of time I am omitting even a shorter prepared text and will be going with some rather general statements. I think that I find that I have to observe that my faculty are going to be delighted to learn that in a short period of time they are going to be earning $400,000 apiece. Our students are not quite as gullible, recognizing that to pay back a $250,000 loan after finishing perhaps a 3 or 4-year residency in a rural area, away from a large hospital, and by accepting medicaid patients is a most interesting kind of challenge.

In terms of statistics, I think it should interest the committee, too, that osteopathic medication has been successful for many years in providing a high percentage of primary care physicians, roughly 90 percent. Of that 90 percent, over 100 practice in communities of 50,000 or less. Something like 16 percent practice in communities of 500,000 or more.

The fact that I represent an institution that is located 90 miles from the largest urban area, and that I represent an institution that is the oldest rural based institution in America has been a major factor in that particular record. I term it as the element of persuasion in student life. We are very interested in the Federal bills that are before us. We are particularly interested in that particular kind of Federal support that is tied more clearly to functional capabilities of institutions. We are in favor of general institutional support. I have to say that up front.

But we favor also the incentive and disincentive approach as adopted in S. 2375 which ties in general approach to the specified national policies. Given orientation and heavy emphasis on undergraduate medical education, we favor faculty development enrichment programs very highly, and certainly encourage the inclusion of greater support for that kind of activity in Federal legislation.

We do not feel that the undergraduate portion of the curriculum has received adequate Federal funding in the past. We are interested in interest deferment on student loans, particularly for those students who have entered the 4-year postgraduate model as it is practiced in the osteopathic legislation.

Our particular program demands of all graduates of our institution a rotating internship before residency begins, which really adds a year to the total time span. This has not been adequately recognized in previous legislation. We are pleased to see support for clinical training and ambulatory and office space settings. It certainly fits the American osteopathic model.

I would like to compliment Senator Schweiker for the remote site training in his bill. We have had success in this because of our students to rural and remote site areas. We urge the inclusion of specific authority for the purpose of developing and enhancing ambulatory and remote site training opportunities for both pre- and postdoctoral osteopathic students.

The 14 colleges of osteopathic medicine are collectively a national resource, providing the sole focus of instruction in osteopathic principles and practice. We firmly believe that the time has come for Congress to recognize the unique contribution osteopathic medical education has made to the alleviation of health care problems in this country by designing legislation which will allow our colleges to move toward full realization of their role as a separate and equal partner in federally supported health manpower training programs.

It is a pleasure to be here with you today representing not only the College of Osteopathic Medicine but also the American Association of Colleges of Osteopathic Medicine.

[The prepared statement of Dr. Moore follows:]

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Testimony of the

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

relative to

S. 2144, S. 2375, REVISIONS AND EXTENSION OF

HEALTH MANPOWER TRAINING PROGRAMS PURSUANT TO

TITLES VII AND VIII OF THE PUBLIC HEALTH SERVICE ACT

This statement has been endorsed by the American Osteopathic Association and the American Osteopathic Hospital Association, which join with us in seeking a viable and effective continuation of federal support for health manpower education consistent with the unique structure and emphasis of osteopathic medical education.

INTRODUCTION

Throughout its history the osteopathic profession, represented by more than 17,000 practitioners in the United States, has worked to provide quality primary medical care. More than 91 percent of all osteopathic physicians are currently engaged in the delivery of primary care services, striking evidence of the significant contribution the osteopathic profession has made to meeting the national goal of making medical care available to all Americans.

In a similar manner osteopathic physicians have made highly effective contributions to assuring access to care for persons living in geographical areas experiencing chronic health manpower shortages. The traditional emphasis of osteopathic medicine on family/general practice in the medically underserved regions of this nation is perhaps the only systematic effort in the private sector toward this goal ever undertaken. The osteopathic profession currently deploys 67 percent of its manpower in the nation's largest and smallest communities, the areas of greatest need: 50.5 percent in communities of 50,000 or less and 16.9 percent in communities of 500,000 or more.

Another area of national concern -- the rising cost of health services -- has likewise been a matter of importance to osteopathic physicians in terms of their practice patterns and hospital utilization. The profession's continuing emphasis upon ambulatory care as the preferred locus of treatment has over the years perpetuated a model of efficiency and cost-effectiveness.

Today the osteopathic profession is on the threshold of unparalleled expansion. During the 1970's the number of colleges of osteopathic medicine doubled (from 7 to 14), with additional colleges in the planning stages; during that same period enrollments more than doubled, and will double again by the end of the 1980's. The numbers of women and minorities entering the profession is greater than before, and is rising steadily. By the time the current freshman class graduates, the total number of osteopathic physicians will have risen by nearly 25 percent, the bulk of whom will be primary care practitioners.

Osteopathic medical education has historically played a major role in alleviating shortages in those areas in which primary care practitioners are most needed. Perhaps more than any other health profession, osteopathic physicians, and the colleges which prepare them, have been instrumental in meeting the nation's commitment to assuring its citizens of access to timely, pertinent, quality health care.

Impact of P.L. 94-484 on Osteopathic Medical Education

The Health Professions Educational Assistance Act has unquestionably been a vital element in assuring the continued ability of the colleges of osteopathic medicine to address national needs through their training programs. Lacking the impetus of federal support, it is unlikely that the colleges could have undertaken the dramatic increases in student enrollment and the development/expansion of facilities needed to address the acute geographic and specialty maldistribution problems identified by Congress.

In their commitment to assuring an adequate flow of primary care practitioners to those areas of greatest medical need, the colleges of osteopathic medicine have utilized with particular success those provisions of the law relating to institutional support, perhaps the single most effective method of promoting stability and increasing the capacity of the schools to respond effectively to national health priorities; start-up assistance, which has assisted the growth of new osteopathic medical schools; and family medicine training grants, which have allowed the colleges to refine and expand their ability to prepare family practitioners.

With regard to student assistance, the record is somewhat less sanguine. In keeping with osteopathic medicine's emphasis upon service in rural areas many students have chosen to finance their education through the National Health Service Corps Scholarship program, which boasts a disproportionately large number of osteopathic students, many of whom will choose to enter private practice in the same geographical area in which they fulfilled their service obligation. On the other hand, the Health Education Assistance Loan program has proven a dismal failure, due to its noncompetive 12 percent interest rate which, for example, would commit a student borrowing $8,000 per year throughout the four years of medical education to a crippling repayment of $148,000 over a 15-year period. Similarly, the Health Professions Student Loan program, currently being phased out, cannot continue to provide the level of support required by osteopathic students to finance their education.

Other sections of the law of potential benefit to osteopathic medical education have been only recently funded (e.g., Section 780, Departments of Family Medicine), or not funded at all, making assessment of their effectiveness impossible at this time.

In short, the experiences of the colleges of osteopathic medicine with P.L. 94-484 have been mixed. Many of the issues which they were designed to remedy are still with us: a continuing lack of adequate numbers of primary care physicians; problems of geographic maldistribution of health care (particularly primary care) personnel; continued underrepresentation of disadvantaged students in health professions schools; and spiralling health care costs. The colleges of osteopathic medicine are concerned by the apparent ineffectiveness of current legislative mandates in solving the health care problems of this nation. We are convinced that by tying federal support more closely and realistically to the functional capabilities of the health professions schools, and by rewarding demonstrated institutional responsiveness to national health priorities, the needs of all Americans can best be served. To this end we offer our suggestions relative to revision of selected areas of current legislation.

GENERAL RECOMMENDATION
HEALTH MANPOWER EDUCATION

A. Institutional Support

The colleges of osteopathic medicine are deeply distressed at the proposed elimination of general institutional support, whose nonspecific thrust has permitted health professions schools to develop and implement responses to national health priorities in a linear and cohesive manner consistent with effective planning. The deleterious effect of a massive and abrupt disruption of such support on the quality of educational programming and on the maintenance of institutional stability cannot be overstated: without question the failure to continue adequate core support will spell the death of health professions education as we know it.

Despite good-faith attempts on the part of the schools to address specific national health care goals, there has been a surprising and, we believe, ill-advised erosion of federal support for general institutional funding, which assists schools in maintaining overall quality. It is unrealistic to expect continued programmatic responsiveness to national priorities by institutions which are financially beleaguered. Unless a realistic level of support is maintained while schools are seeking to identify and develop alternative funding bases, an institution's only recourse will be to increase tuition dramatically and/or curtial academic and clinial training programs in order to insure its survival: and even then survival will not be a certainty. Moreover, students required to raise even more capital to meet large tuition increases will as practitioners be forced to adopt a fee structure consistent with their enlarged debt load, a practice which can only exacerbate the already spiralling costs of health care.

We fully understand the concern of Congress that health professions schools make a tangible commitment to meeting national needs, and we recognize the logic of tying some level of federal support to such a commitment. However, we utterly reject the supposition that the of general institutional support by a narrower, more exclusionary special project emphasis of the type proposed in S. 2144 will foster the academic environment necessary to assure both the fulfillment of national objectives and the quality and continuity of the educational process. Special project support linked to specific programmatic activities of a limited and highly specialized nature cannot conceivably replace capitation in either magnitude or intent, nor should it be expected to do so.

In place of this extremely limited approach we prefer the incentive/disincentive approach adopted in S. 2375, which, while recognizing the validity of general institutional support, ties such funding to the attainment of specified national goals consistent with federal health and fiscal policies. In this manner attention to areas of national priority is assured, while overall institutional strength is preserved as a fundamental building block of long-range health manpower development.

A related mechanism for assuring the most effective use of institutional support is to tie grants to output, in effect rewarding those institutions with a strong record of producing practitioners directly responsive to identified national needs. In this way the cost benefit of incentive payments can be accurately gauged, and an adequate supply of primary care physicians assured. The institutional support grant distribution formula could be modified so that, for example, grants are largest for schools which already have trained primary care physicians for medically underserved areas, and smaller or nonexistent for medical schools whose graduates have chosen to practice in areas of geographic or specialty surplus. This same output correlation mechanism can be effectively applied to project grants and contracts as well, for example by rewarding schools with an established record of producing primary care rural physicians, or otherwise emphasizing retroactive eligibility to conform to specified national goals and priorities. The validity of the output reward theory has already been seconded in the October 1979 report of the National Center for Health Services Research, Medical Education Financing: Issues and Options, which we commend to your attention.

Keying institutional support to specific output goals is an approach which the American Association of Colleges of Osteopathic Medicine has long advocated as the most equitable and effective means of insuring that schools already meeting national health manpower training priorities are not penalized by their success. Too often in the past colleges of osteopathic medicine have been effectively barred from receiving federal education support because they already have actively functioning programs in areas of national need.

B. Student Assistance

Federally-supported financial assistance for students in the health professions has proven a highly successful, cost-effective mechanism for assuring the availability of an adequate supply of practitioners, and for encouraging low- and middle-income students to enter the health manpower work force. Without energetic and continuing support of this nature student debt loans, already ranging as high as $60,000 in some cases, will increase drastically, and will be passed on to consumers as health care costs rise to offset increases in practitioners' educationally incurred financial obligations. Moreover, without adequate sources of support, economics rather than talent will determine the composition of the student pool, to the detriment of both quality and equality of opportunity.

With regard to the philosophy underlying federally-supported programs of student assistance, we endorse a pluralistic mix of scholarship, subsidized loan, and conventional loan programs. Sufficient variety should exist to offer adequate opportunities for students to participate in health professions education in a manner most appropriate to their financial situation, while eliminating to a significant extent the crushing debt loan with which many students currently emerge from their academic and first-level clinical training. We find the following program elements of current law particularly noteworthy:

> National Health Service Corps - Osteopathic students have availed themselves of National Health Service Corps (NHSC) scholarships and entered practice in medically underserved areas at a level disproportionately high compared to the percentage of practitioners in the physician population, and we look to continuation of the NHSC scholarship program as a student support mechanism singularly appropriate to the practice pattern of the majority of D.O.'s The existing program is a proven and effective mechanism for channelling health care services to shortage areas. A primary strength of the program has been its nationwide focus, which has enabled identification and response to spot shortages as they arise.
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> We urge preservation of the program within its current parameters, and would oppose any state-based system, under which its national resource coordination capability and ability to adjust assignments to fluctuations in need would be irretrievably damaged. If a state-based service commitment is deemed advisable, it can more appropriately be addressed through an administrative than a statutory remedy, for example, by providing that assignment priorities reflect the desirability of a service commitment in an individual's state of residence or primary financial obligation.
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> Health Professions Student Loan Program - We find the proposed elimination of the Health Professions Student Loan Program particularly unfortunate. This program, the most popular of the student assistance

options under current law, has just begun to recapitalize on the basis of loan repayments, and early indications point to an unusually low default rate (less than 2 percent). Even without the appropriation of new monies the program is in a position to be self-supporting through the rollover of incoming repayments for new loans. Support for proven loan programs such as this one must be viewed as a priority if freedom of career choice regardless of economic status is to be assured.

Health Education Assistance Loan and Loan Subsidies- The Health Education Assistance Loan (HEAL) program's pyramiding interest rates have rendered it so unattractive as to be virtually dysfunctional. The continuation of federal loan subsidies is essential to assure that the burdensome interest rate which has caused the HEAL program to fail is not imposed upon other federally-supported loan arrangements as well. To this end, in addition to the assurance of an ongoing federally commitment to loan subsidies, we would support the provision of graduated and extended repayment options, and the restructuring of loan ceilings to reflect actual educational costs. If such assistance is not provided the cost of health care will inevitably escalate, as practitioners attempt to cope with repayment problems.

Interest Deferrals - While we support the twin concepts of interest subsidies and deferrals for students undertaking postdoctoral training (particularly in specialty areas of demonstrated national need), we are dismayed at the proposal to limit such subsidies and deferrals to a period of three years following graduation. This approach discriminates against the osteopathic educational model, which mandates a one-year rotating internship for all students in addition to an optional three-year residency, a total of four years of postdoctoral training in contrast to the three traditional for allopathic graduates. It is imperative that osteopathic students be guaranteed the same level of support (extending through the internship and residency) as their allopathic peers. A similar problem involving NHSC deferments exceeding the three-year maximum (again predicated upon an allopathic model) was recently resolved in "The Nurse Training Amendments of 1979" (P.L. 96-76) by the addition of language providing for Secretarial discretion in extending deferral periods. We would hope that the requisite flexibility can be included in the language of the law rather than through post facto amendment.

C. Minority Enrollment

Although we remain supportive of continued special efforts directed toward disadvantaged students, the limited amounts made available under these programs in the past have been insufficient to create the desired effect. This situation is particularly acute in the case of programs targeted at the attraction and retention of minority students. While we applaud recommendations to expand such programs to embrace a broad range of functional capabilities, a comprehensive program should not be undertaken unless a meaningful level of support is assured. Particularly in the case of small schools lacking affiliation with a large university system, the availability of faculty to provide the necessary counseling, remedial, and socialization support cannot be guaranteed. Without the presence on staff of one or more individuals committed solely to overseeing the various aspects of the proposed program, responsibility for operating it will devolve upon staff members already overworked, with predictably dissatisfying results.

Despite chronic underfunding, programs such as the Health Careers Opportunities Program (HCOP) have managed to produce impressive results. Through a HCOP grant the American Association of Colleges of Osteopathic Medicine has established an Office of Special Opportunities (OSO) to increase the representation of ethnic disadvantaged students in colleges of osteopathic medicine. Administered in cooperation with a consortium of ten colleges of osteopathic medicine, the program provides a variety of services to individual schools to stimulate local initiatives such as undergraduate recruitment, summer preceptorships, pre- and post- admission academic reinforcement, and peer counseling. Through the OSO a national osteopathic career information service has been made available to students, counselors, and advisors at both secondary and predoctoral levels. The HCOP approach works; but if minority recruitment and retention activities are to register more than token gains, the federal commitment to such programs must be meaningfully augmented.

D. Faculty Development and Enrichment

Faculty development has failed to receive adequate attention in terms of federal funding, due in large measure to its linkage with primary care residency training under a single authority. Inevitably, residency programs have siphoned off the available support while faculty-oriented programs have been bypassed. The attraction, retention, and development of qualified faculty poses a particular problem for developing institutions, which have not yet reached capacity in acquiring and integrating a broad spectrum of departmental and programmatic resources into their academic structures. With respect to faculty enrichment, time and site limitations imposed by the regulations implementing these provisions of current law have created further disincentives to participation in continuing medical education activities, particularly by clinician faculty members with heavy practice commitments.

We are therefore gratified to observe a resurgence of interest in faculty development in both health manpower proposals, and we endorse it as a long-overdue recognition of the need to insure the continued ability of health professions faculty to respond appropriately and sensitively to the changing needs of the field. However, past experience suggests that without a specific authorization for these activities they are likely to be ignored in favor of increased allocations for residency training programs. For this reason we recommend either separate funding or an earmark of the type authorized in S. 2375 specifically for faculty development.

E. Osteopathic-Specific Recommendations

The foregoing comments have been geared to issues affecting health professions education generally. However, as indicated in our introductory remarks, in several cases the needs of osteopathic medical education are unique, and should be addressed through legislation designed specifically with the osteopathic curriculum in mind. The following are areas in which we believe particular attention is merited.

Predoctoral Training and Primary Care

Osteopathic physicians receive a major portion of their primary care training as undergraduates. For this reason the allopathic residency model on which P.L. 94-484 is predicated (and to which the bulk of its funding is directed) bears little relevance to the training models employed by colleges of osteopathic medicine. While we have no desire to de-emphasize the importance of residency training programs for osteopathic physicians, we find the gradual erosion of support to undergraduate medical education intensely distressing.

It has been observed, and rightly so, that D.O.'s are "developed" as general practitioners and "retrained" as specialists, while for most M.D.'s the reverse is true. A primary focus on general/family medicine characterizes the entire predoctoral curriculum in colleges of osteopathic medicine; and for this reason predoctoral osteopathic education programs are deserving of federal recognition and support consistent with their function as a -- perhaps the -- major training ground for primary care physicians in the United States. The flow of greatly needed funds to this level of osteopathic medical education must be assured, for it is here, in the area of predoctoral educational activity, that the greatest potential exists to attract and educate significant numbers of students to primary care practice.

Neither S. 2144 nor what we understand to be the Administration approach to funding primary care training programs is adequately sensitized to this unique aspect of osteopathic medical education. Repeatedly funding and categorical proposals relative to primary care training are linked to language creating a preference for or actually requiring as a condition of eligibility the conduct of residency programs in general internal medicine, general pediatrics, and family medicine. The encouragement of osteopathic residencies in these areas is largely irrelevant to the practice patterns of the field, and certainly redundant in terms of the osteopathic curriculum. Not only does this approach overlook the primary strength of the osteopathic educational model, it actually discriminates against osteopathic colleges in competing with allopathic institutions for support by penalizing our schools for past successes in training primary care physicians under an alternate educational model.

Although we have no objection to continuing the primary care residency authority, we deem it essential that equal attention and equal support be provided to primary care programs at the undergraduate and osteopathic internship levels. We are thus particularly appreciative of the inclusion of such a component in S. 2375. Until such support is assured through a specifically designated authority osteopathic medical education -- ironically, the largest and most historically successful provider of primary care physicians to the nation -- will continue to be discriminated against in the receipt of federal funds for the type of training they do best.

Family Medicine

The need to undertake specific efforts with respect to the support of predoctoral family medicine education has been addressed by implication in the preceding section under the broader rubric of primary care training. Again we emphasize the necessity of providing assistance to predoctoral curricula already targeted at preparing the type of practitioner best suited to ameliorate geographic and speciality distribution problems: the family physician.

As has been previously noted, because Section 780 has only recently been funded no evaluation can be made at this time regarding the effectiveness of that provision of the law in spurring the development of family physicians. Nonetheless, we believe it necessary to underscore the conceptual inequity of current federal approaches to departmental support in this area. Many colleges of osteopathic medicine established departments of of family medicine as integral components of their educational program long before the advent of federal incentives to do so. These schools are not experiencing the same level of recognition and support as are schools with departments newly-established or in the planning stage. We have already reviewed the merits of an output-related support mechanism within the context of institutional funding. This approach is equally applicable to departments of family medicine, for by providing tangible recognition and assistance to schools already fulfilling national health goals relative to primary care, Congress can continue to encourage a commitment to family medicine education while providing the means whereby established departments can improve the scope and quality of their activities. We therefore urge the extension of federal support to departments of family medicine which have a proven record of responsiveness to the need for educating family physicians.

Ambulatory Care/Remote Site Training

We are pleased to note in both proposals the inclusion of support for clinical training, particularly those provisions granting special consideration to projects emphasizing training in ambulatory and office-based settings and in medically underserved areas. This emphasis is consistent with the preceptorship and remote-site training components of osteopathic medical education, as well as the profession's traditional emphasis on service in physician shortage areas.

One factor influencing the osteopathic profession's marked success in attracting and retaining practitioners in medical shortage areas has been the exposure of students early and repeatedly during their clinical training to practice in remote-site ambulatory settings. Although the value of remote-site training has been recognized both in the proposals currently before us and in the osteopathic-specific institutional support provisions of P.L. 94-484, little tangible support has been made available for this type of training. While it is unquestionably a cost-effective activity both in terms of providing direct services in underserved areas and developing practioners skilled and interested in making a long-term career commitment in this area, it is also an expensive process which will require federal support if it is to continue and grow. For this reason we urge the inclusion of specific authority for the purpose of developing and enhancing ambulatory -- and particularly remote-site -- training opportunities for both pre- and postdoctoral osteopathic students.

SUMMARY

In conclusion, we find that while the current law seeks to redress imbalances in nationwide physician distribution, it does so largely within the context of the allopathic educational model. As a result colleges of osteopathic medicine, despite their long history of successes stemming from a somewhat different educational orientation and structure, have not been accorded equal emphasis by or access to many programs under P.L. 94-484. Predoctoral osteopathic medical education has received relatively little attention or encouragement from federal sources; a causal relationship between funding and output has not been established; requirements geared toward allopathic schools have frequently acted as a constraint upon osteopathic programs.

The 14 colleges of osteopathic medicine are collectively a national resource, providing the sole focus of instruction in osteopathic principles and practice. We firmly believe that the time has come for Congress to recognize the unique contribution osteopathic medical education has made to the alleviation of health care problems in this country by designing legislation which will allow our colleges to move toward full realization of their role as a separate and equal partner in federally-supported health manpower training programs. The colleges are sensitive to the continuing need to train primary care professionals, and are singualarly qualified to meet that need. We welcome this opportunity to meet with those individuals directly involved in shaping national health manpower policy, and we look forward to an ongoing and mutually productive dialogue.

Senator **METZENBAUM**. Thank you very much, Doctor.

The Chair notes with interest that a group of young people have joined us from the Friends School, and I thought they might be interested in what we are doing.

This is a hearing of the Health Subcommittee of the Senate and we are talking about various programs that the administration has proposed and other Members of the Senate have proposed to help young people who want to attend either our medical colleges or osteopathic colleges, and colleges for other health professions. These are witnesses appearing here representing various segments of those professions.

We would like to welcome you here this morning.

Our next witness is Dr. Mann, dean of the University of Mississippi School of Dentistry.

Dr. **MANN**. My name is Wallace Mann. I am dean of the University of Mississippi College of Dentistry and am speaking on behalf of that organization.

Mr. Chairman, the American Association of Dental Schools believes that the preferred approach to the problem of student assistance is that of S. 1642, the Health Professions Training Amendments of 1979, introduced by Senator Schweiker in August of 1979. S. 1642 would build on existing loan and scholarship programs by including, among others, provisions for interest subsidies for health education assistance loan recipients, elimination of the prohibition on HEAL recipients from receiving other Government loans, extension of the repayment period for health professions student loans and continuation of the exceptional financial need scholarship program. In addition, this bill, like S. 2375 and S. 2144, would effect a much needed graduated repayment provision. We believe that the thrust of S. 1642 in incrementally improving the features of the working system is a sound approach to the complexities of the student assistance problems.

We think the loan repayment program, if adequately funded, is much more effective in meeting the needs of shortage areas than are other need targeted programs. In our opinion, graduates who avail themselves of loan repayment would be more likely to remain in an area that needs dentists than an individual who made a commitment to serve in a need area as a precondition to receipt of a loan or scholarship early in his or her dental education.

We think that Senator Kennedy's recommendation would prove the most feasible. The one modification that we would suggest would be increasing the payback amount for principal from 80 percent to 100 percent. This would enhance the attractiveness of the program and provide a greater incentive for individuals to avail themselves of it.

We believe that retention of the direct student loan program, such as the current professions student loan program, would be more realistic. Given reasonable time, the existing health professions student loan program will begin to roll over to the extent that the need for continued Federal capital contributions should be substantially reduced.

We urge that the authority for this program be continued but amended to provide scholarship support for more than 1 year for the student who has an exceptional financial need and that adequate appropriations are provided each year.

The association endorses the continuation of institutional support for health professions schools and believes that some of the health principles contained in the National Priority Incentive Grant package in S. 2375 will help schools maintain fiscal stability. However, we recommended modification in the plan.

The incentive provisions in section 772(e)(2) will be, for the most part, very difficult for dental schools to meet. The A and B provisions will be particularly difficult because the national applicant pool does not have 15-percent minority students from undeserved minority groups or 40-percent women.

Also, the provision in 772(e)(C)(i) that 90 percent of graduates will enter general practice will be difficult for schools to assume because the practice of pedodontics and public health require advanced education that occurs after dental school and the dental schools have little or no contact with students after graduation. The provision of (C)(ii) is troublesome because very few dental schools have residencies in public health or general practice.

In part D we suggest that the incentive relate to States without dental schools rather than health manpower shortage areas. This would be particularly relevant to the problem of health manpower distribution because 17 States do not have dental schools. The offsite training provision is very costly for dental schools and could cost up to three to four times more per student than the institution would receive from the basic support. We suggest that this provision of part D be an optional rather than a given assurance. We believe that substantial education in prevention of dental disease or community dentistry should be mandatory as one of the two educational areas enumerated in paragraph E.

In addition, we suggest that other incentive options be made available which would further the ability of the schools to address national priorities.

The association supports the proposal to continue some existing project grant authorities in S. 2144. In addition, we endorse the proposed new grant authorities for professional support mechanisms for physicians and dentists practicing in medically underserved areas, curriculum development in health care economics, continuing education projects and projects to demonstrate means of reducing the cost of health professions education and curriculum development.

Senator Kennedy has proposed combining the expanded function dental auxiliary program, the TEAM program and the general practice residency program into one category entitled "Dental Education." I do not object to this approach. However, we believe that 70 percent of the authorization level should be earmarked for the general practice residency program.

The American Association of Dental Schools strongly supports sections 791, 795, 796, and 797 of S. 2375.

Senator METZENBAUM. Would you wind up, please, Doctor?

Dr. MANN. Yes.

The association supports the basic concept of S. 2144 in phasing down the National Health Service Corps Scholarship program to a level that is consistent with realistic shortage area requirements. To assure that the scholarships are available for dental students to meet the assignment needs, we suggest that the funds be earmarked for those students.

I appreciate the opportunity to appear before this subcommittee, and I will be pleased to answer any questions which you or Senator Schweiker may have.

[The prepared statement of Dr. Mann follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS
SUBMITTED TO
THE SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
March 10, 1980

Mr. Chairman and other distinguished members of the Subcommittee, my name is Dr. Wallace Mann and I am Dean of the University of Mississippi College of Dentistry and President-Elect of the American Association of Dental Schools and speaking on behalf of that Association. I am pleased to present the AADS response and recommendations to the various proposals for reauthorization of health manpower authorities before this Subcommittee.

I shall address the individual programs of special importance to dental education in approximately the order that they appear in S. 2375, but I will be referring both to Senator Kennedy's bill (S. 2375) and to Senator Schweiker's bills (S. 1642 and S. 2144) in the course of my testimony.

Construction Grants

The Association believes that funds should be provided under the construction grant authority to permit replacement of equipment and renovation of outmoded teaching facilities. Although most dental schools have been built, replaced or renovated within the past fifteen years, many need to replace equipment and modernize their educational facilities to keep pace with changing technology. Unlike medical schools which ordinarily have access to hospitals and their clinical equipment, dental schools are largely self contained and must provide their own high cost equipment. Because this equipment is utilized daily and technology changes, it becomes worn and needs to be replaced in a short period of time.

In our judgment, the construction authority proposed in Senator Schweiker's bill, S. 2144 most closely approximates the needs of the dental schools. Under this proposal, grants, loan guarantees, and interest subsidies would be available for renovation, modernization, or conversion of existing facilities for use as ambulatory primary care teaching facilities. Assuming the terms "renovation" and "modernization" imply equipment replacement, that approach would permit schools to seek financial assistance to make necessary changes and improvements in their clinical facilities.

We also endorse the provision releasing previous recipients of construction grants from their assurances regarding maintenance of enrollment increases for a period of twenty years. This would allow dental schools to keep enrollments at a level that is more consistent with their operating resources and the need for dentists.

Student Assistance

Mr. Chairman, the American Association of Dental Schools believes that the preferred approach to the problem of student assistance is that of S. 1642, the Health Professions Training Amendments of 1979, introduced by Senator Schweiker in August, 1979. S. 1642 would build on existing loan and scholarship programs by including, among others, provisions for interest subsidies for Health Education Assistance Loan (HEAL) recipients, elimination of the prohibition on HEAL recipients from receiving other government loans, extension of the repayment period for Health Professions Student Loans (HPSL) and continuation of the Exceptional Financial Need (EFN) Scholarship program. In addition, this bill, like S. 2375 and S. 2144, would effect a much needed graduated repayment provision. Such a provision would allow young practitioners to repay their indebtedness in keeping with the growth of their practice. We believe that the thrust of S. 1642 in incrementally improving the features of a working system is a sound approach to the complexities of the student assistance problems.

While the Association sees merit in the concept of a new needs-based, campus oriented loan program for health professions students as proposed by Senator Kennedy, we are concerned that the cost of such a program to the federal government would be extraordinarily high and that a successful direct loan program that has operated for many years would be eliminated. In addition, we would favor an expanded loan repayment program over the service commitment features of S. 2375. We think the loan repayment program if adequately funded is much more effective in meeting the needs of shortage areas than are other need targeted programs. In our opinion, graduates who avail themselves of loan repayment would be more likely to remain in an area that needs dentists than an individual who made a commitment to serve in a need area as a precondition to receipt of a loan or scholarship early in his or her dental education.

We believe that retention of a direct student loan program such as the current Health Professions Student Loan Program would be more realistic than a two tiered guaranteed student loan program given current loan market conditions. If dental students are forced to rely primarily on the private loan community, they may find little or no loan money actually available. Current market conditions tend to make student loan packages less attractive to lenders because of the interest rate that lenders must pay to provide the capital, the number of repayment years, and the higher rates of returns of other types of loans. Given reasonable time, the existing Health Professions Student Loan Program will begin to "roll over" to the extent that the need for continued federal capital contributions should be substantially reduced. We support the extension of the current Health Professions Student Loan program without further capitalization if fiscal constraints dictate that it is not possible to provide annual federal capital through appropriations each year.

The Health Education Assistance Loan program while undesirable in its current form could be much more attractive and relevant with the interest subsidies and graduated repayment provisions contained in S. 1642. In addition, the lifting of the prohibition on the HEAL recipient from receiving any other loan concurrently with a HEAL loan would make it a realistic supplement to less onerous forms of financial assistance.

Finally, we believe that the Exceptional Financial Need Scholarship program should be retained but amended. This program has been an important resource for dental students who otherwise would be unable to obtain a dental education. Unfortunately, appropriations for this program have been low and only one or two scholarships have been available to each dental school. We urge that the authority for this program be continued but amended to provide scholarship support for more than one year for the student who has an exceptional financial need and that adequate appropriations are provided each year.

Loan Forgiveness

As we indicated previously, we believe that the loan forgiveness program is the most effective mechanism for encouraging practitioners to locate in an underserved area on a long-term basis. Accordingly, we are pleased that all of the manpower reauthorization bills currently before this Subcommittee would continue this program with modifications.

Among those proposals, we think that Senator Kennedy's recommendation would prove the most feasible. It covers all educational loans on a yearly, incremental basis. The one modification that we would suggest would be increasing the payback amount for principal from 80 percent to 100 percent. This would enhance the attractiveness of the program and provide a greater incentive for individuals to avail themselves of it.

Institutional Support

Mr. Chairman, the Association endorses the continuation of institutional support for health professions schools and believes that some of the principles contained in the National Priority Incentive Grant package in S. 2375 will help schools maintain fiscal stability. At the present time, significant amounts of Federal institutional funds to dental schools are used to support full and part-time faculties and staff. Without Federal support dental schools in general would have to obtain replacement funds to support up to almost 57 percent of faculty and staff salaries. Private dental schools would have to obtain sufficient replacement funds for almost 62 percent of its faculty and staff salaries.

The incentive provisions in Section 772(e)(2) will be for the most part very difficult for dental schools to meet. The (A) and (B) provisions will be particularly difficult because the national applicant pool does not have fifteen percent minority students from underserved minority groups or forty percent women. Without qualified applicants the schools could not meet those incentives. Also, the provision in 772(e)(2)(C)(i) that 90 percent of graduates will enter general practice will be difficult for schools to assume because the practice of pedodontics and public health require advanced education that occurs after dental school and the dental schools have little or no contact with students after graduation. The provision of (C)(ii) is troublesome because very few dental schools have residencies in public health or general practice. The training for the latter exists for the most part in hospitals not affiliated with dental schools. In part (D) we suggest that the incentive relate to states without dental schools rather than health manpower shortage areas. This would be particularly relevant to the problem of health manpower distribution because seventeen states do not have dental schools. The offsite training provision is very costly for dental schools and could cost up to three to four times more per student than the institution would receive from the basic support. We suggest that this provision of part (D) be an optional rather than a given assurance. We endorse (E) and believe that it is a realistic component to meet stated health goals. We believe that substantial education in prevention of dental disease or community dentistry should be mandatory as one of the two educational areas enumerated in paragraph (E).

The disincentives contained in Section 772(e)(3)(A) are next to impossible for private schools that have no public support and we suggest that a waiver provision be added for such schools. Clause (B) is most appropriate and we can endorse that provision. In addition, we suggest that other incentive options be made available which would further the ability of the schools to address national priorities. Section 731(c)3(b) of S. 2144 provides that "the school conducts, or plans to conduct within 12 months, a community dental education and screening program designed to either (i) educate and screen the general population for controllable dental diseases or conditions; or (ii) meet the dental education needs of a defined special population, such as the handicapped, elderly, indigent, or institutionalized children." Section 731(c)(4)(B) of that bill states "the school provides or coordinates with an existing system to provide, or plans to do so within twelve months, a program for the delivery of primary or preventive dental care services to an underserved population, such as local prisoners or public nursing home residents." Both 731(c)(4)(B) and 731(c)(3)(B) are direct service oriented and in our judgment provide schools with the opportunities to address the dental health care needs of populations within a community. We recommend that such provisions be included in the list of options available to dental schools under the Kennedy National Priority Incentive Program rather than those provisions in S. 2375 that are impractical or impossible for dental schools.

Again, we emphasize that these assurances must be within the context of institutional support. We do not think that these objectives can be realized through project grant authorities because special project grants are targeted authorities, carry a forward commitment for operating resources, and do not provide basic financial assistance to the dental schools.

We suggest that each of these eight incentives carry an increase factor of .50 of the base grant as proposed in S. 2375. However, we also recommend that funding be limited to a maximum of five incentives per institution. In other words, while a school might comply with more than five of the incentives, they would be eligible to receive only the base grant plus the incentive of 5 times .50 of the base grant. We believe that an incentive program such as we have suggested will meet national priorities, assist in establishing fiscal viability and be realistic and practical for dental schools.

Special Projects

The Association supports the proposal to continue some existing project grant authorities including general practice of dentistry residencies, AHECs, expanded function dental auxiliaries, TEAM interdisciplinary training, educational assistance to individuals from disadvantaged backgrounds, and curriculum development.

In addition, we endorse the proposed new grant authorities for professional support mechanisms for physicians and dentists practicing in medically underserved areas, curriculum development in health care economics, continuing education projects and projects to demonstrate means of reducing the cost of health professions education and curriculum development. These programs fall properly within the concept of project grant support.

While the Association believes that the objectives of Section 731(c) of S. 2144 are well conceived, we think that these objectives would be realized to a greater extent as optional assurances in a context of institutional support rather than project grants as we have indicated above.

Senator Kennedy has proposed combining the expanded function dental auxiliary program, the TEAM program and the general practice residency program into one category entitled Dental Education. While we have no objections to this approach, we believe that seventy percent of the authorization levels should be earmarked for the general practice residency program. The general practice residency program has proven to be effective in enhancing the competence and confidence of dental graduates and prepares them to be effective and efficient practitioners in general dentistry in keeping with stated national objectives. We believe that the major emphasis of Section 786 should be directed to general practice residencies in dental schools and accredited programs in hospitals and other appropriate entities.

Mr. Chairman, the American Association of Dental Schools strongly supports Section 791 of S. 2375 providing special project funding to (1) develop new admissions policies, procedures, and criteria to increase the enrollment of students who are committed to serve underserved populations, who are residents of underserved areas or who are likely to enter general practice; (2) plan, develop, and operate, or maintain clinical education programs including preceptorships and interdisciplinary training in underserved areas or in health manpower shortage areas; or (3) plan, develop, and operate, or maintain programs to provide individuals who meet or plan to meet the needs of underserved populations, education including continuing education and training related to the delivery of health care to medically underserved populations. All of these functions are of great importance and these project grant authorizations would significantly further the current efforts of the dental schools in these directions.

The Association also believes that Section 793 of S. 2375 is particularly well-conceived. However, as mentioned earlier we believe that preventive dentistry, continuing education and faculty development are particularly important and should be included as institutional grant assurances.

We endorse Section 795 of Senator Kennedy's bill dealing with special project grants in nutrition, geriatrics, rehabilitation and the containment of health care costs; as well as Section 796 providing funds to schools to increase the participation of women in health careers; and Section 797 providing for research and demonstration projects. All of these functions are in the best interests of the dental schools that have the resources to develop such programs and the nation at large.

Financial Distress

The Association believes that the financial distress authority should adequately reflect the magnitude of need that could result if institutions faced unexpected financial problems. Both the Schweiker and Kennedy proposals appropriately imply that these funds are to correct financial problems and not to provide continuing assistance for any school. In addition, S. 2375 clearly distinguishes a separate subpart of the financial distress section dealing with the financial problems of predominately minority schools. While we think it wise to address the unique difficulties of minority schools, we are concerned that Section 788 B(6) of Senator Kennedy's bill states in effect that if funds are appropriated in any fiscal year to fund financial distress grants, they will first go to minority schools and if exhausted at that point, other schools would have no funds available. In light of recent Congressional action to cut appropriations to health manpower programs, financial distress funds to schools other than minority institutions would be particularly vulnerable. We believe that financial distress funds must be made available to all dental schools and that sufficient amounts be authorized to meet the need of any dental school and particularly private institutions.

The AADS believes that the financial distress approaches included in S. 2144 that establishes two types of financial distress grants for health professions schools is appropriate. The first is similar to existing law, but available for not more than three years and could be used for operating costs, accreditation, and carrying out operational, managerial, and financial reforms. Most importantly this program would be available to all dental schools that have not already received financial distress grants prior to October 1, 1980. S. 2144 has a separate authorization for appropriations for this portion of the financial distress package. The Association supports this separate authorization for appropriations, but we believe that $25 million is a more realistic level for this program than $5 million if those schools that experience serious financial difficulties because of spiraling dental educational costs and reduced federal support are to remain as viable educational programs.

The second component of Senator Schweiker's financial distress section contains authorization for grants, available for up to five years, for schools that have already received financial distress under existing law. To qualify for advanced grants, schools would be required to have an approved plan to achieve financial solvency within five years and a commitment from a state or local government to match the federal distress grant. Authorization levels for this program are separate from those of the first financial distress program. We suggest that Senator Schweiker's proposal that requires matching grants from states, be waived for schools that have tried unsuccessfully to obtain such support. While the matching grant approach is commendable in theory, we are aware that some states have been reluctant to provide support for some schools. Such a provision could impact most severely the minority institutions that need support. We, therefore, recommend that the matching requirement be dropped or waived for national priority schools.

National Health Service Corps Scholarships

The Association supports the basic concept of S. 2144 in phasing down the National Health Service Corps Scholarship program to a level that is consistent with realistic shortage area requirements.

We believe that a program primarily administered at the state level would likely be more responsive to the real problems of meeting the needs of underserved populations. The Association thinks that continued phased down support for NHSC Scholarship authority is appropriate, at least to maintain stability until a substantial shift of responsibility to the states takes place. Continuation of the NHSC Scholarship provisions should not be considered a general student assistance provision and must be coordinated to the needs for career NHSC dentists in state designated shortage areas. In short, we believe that NHSC scholarships should be limited to those dental students that intend to serve in NHSC as a career and the number supported should not exceed the number expected to be needed in the year of graduation and available for service. In the past, the total number of NHSC scholarships available to dental students has been relatively small compared to total enrollments in the dental schools and the total number of scholarship recipients.

The Kennedy bill proposed to earmark 80 percent of NHSC scholarship appropriations for schools of medicine and osteopathy.

To assure that needed scholarships are available for dental students, we suggest that earmarked funds for those students be designated in the authority. Specifically, we request that dentistry be included in the 80 percent allotted to MO schools and that up to 5 percent of the 80 percent be earmarked for dental students.

We are particularly concerned about recent trends to expand the National Health Service Corps Scholarship program at the expense of other student assistance such as the Health Professions Student Loan program and the Exceptional Financial Need Scholarship program. We do not support the concept that the NHSC is the principal source to effect a better distribution of health manpower. Programs such as the National Health Professions Placement Network is a realistic method to match community need and Health manpower availability. NHSC should be the resource available to need areas that have no other way to alleviate shortage of health manpower.

Mr. Chairman, we appreciate the opportunity to appear before this Subcommittee and we will be happy to address any questions you or other members of the Subcommittee may have.

Senator **METZENBAUM**. Thank you very much, Dr. Mann.

Senator Javits, do you have an opening statement?

Senator **JAVITS**. I do have an opening statement. I will make it for the record.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator **JAVITS**. Mr. Chairman, I am pleased to join you today for these hearings to consider legislation which revises and extends the Health Professions Educational Assistance Act and Nurse Training Act, and to welcome each of our witnesses.

This legislation would improve and extend one of the most successful programs this committee has sponsored. We first provided Federal financial support for health professions schools in 1963, in order to address the critical shortages in the supply of doctors, nurses, and other health professionals. This investment in education and training has greatly benefited the American public. Today, the supply of health professions students now in training is almost in balance with the projected need. Furthermore, the number of health professions students preparing for primary care practice has greatly expanded in response to the incentives we have enacted to encourage this trend. I applaud the responsiveness of the health professions educational and training institutions in working with the Congress to achieve these important goals.

Serious problems remain in the distribution of health professionals and in the opportunity to pursue careers in medicine. One fourth of all Americans live in health manpower shortage or medically underserved areas. Even in New York City, with its wealth of medical specialists and teaching institutions, 28 percent of the population is medically underserved, and, in the borough of the Bronx, this figure reaches 59 percent. In addition, many qualified young people are prevented from obtaining a medical education because of its enormous expense. As a result, their communities lose the potential benefit of their service.

The administration may differ with the Congress on the nature and extent of continued support for health professions education programs. That is their prerogative. But, it is our duty to evaluate the need for and the productivity of these programs for the Congress, and I can assure those Americans who are concerned about adequate health care services in their communities that I will not ignore their concerns even in the name of the need for fiscal restraint. We can still do enough to make a difference.

I am pleased to be a cosponsor of S. 2375, the Health Professions Training and Distribution Act of 1980 which provides support for programs which I believe to be both well targeted to national needs and fiscally responsible. I especially favor: (1) Continued support only for those educational institutions which are working to meet national priorities to train health personnel to provide primary care in underserved areas; and (2) support for adequate student assistance programs to assure that all qualified students, particularly those from currently underrepresented minorities, have equal opportunity to receive a health professions education regardless of their socio-economic status.

In addition, I have introduced a separate bill, the Health Care Management and Health Care Personnel Distribution Improvement Act of 1980 (S. 2378) which is designed to address the critical need to improve management in health care, to improve the geographic and specialty distribution of health professionals by focusing on such influential factors as the residency training experience and reimbursement policies, and to avert a potential crisis in hospitals which are heavily dependent on alien foreign medical graduates.

Mr. Chairman, I look forward to hearing the testimony of our witnesses today and later this week on my bill and all other bills being considered by the committee on this issue and working with all members of the committee in the coming months to develop a responsive, fiscally sound piece of legislation.

Senator METZENBAUM. Let me just ask each of you very briefly to respond to just three questions that I have, if you can, because the administration's program just came out rather late.

Dr. Moore, what do you think of the administration's proposal?

Dr. MOORE. What do I think of the administration's proposal?

Do you have any specific question within that rather broad question?

Senator METZENBAUM. Well, what about the elimination of capitation?

Dr. MOORE. Elimination of capitation will hurt. It will increase the cost of medical education primarily to the student. That will certainly hurt the private institution to a far greater degree, in my opinion, than the publicly supported one where I think you will see the costs passed on immediately to the students.

The issue I recognize is complex. The service programs will only handle so many students in the high tuition institution, certainly the payback after graduation is going to be much higher and, therefore, it will be discriminatory to the haves rather than the have nots. I do not think there are too many of our private institutions, and I think I can speak for all medical educations that want to see themselves become the exclusive property of the rich.

Senator METZENBAUM. Dr. Stemmler, do you want to briefly respond to that?

Dr. STEMMLER. I will try to be brief, Mr. Chairman.

I guess we disagree fundamentally with the strategy of the administration's proposal, and I will try to be specific on why.

First, on the aspect of students financial aid, it would seem to me, despite the calculations about future income or costs or manageability of debt burdens, we have to look at two aspects. One is what it looks like to bright young people who want to be physicians and whether the appearance of the funding of their education is really so formidable that they are turning away and we have a feeling that that is occurring.

The second relates to what our society expects from the people who are engaged in receiving their medical education and, in addition, have to manage formidable debts where it is not clear what their ability to bear that debt burden will be.

I guess I disagree with the assumption that physicians' incomes will track in some way, that is a linear calculation for now. I think there is a lot of evidence to think that there are more and more physicians completing their training and that there is a market phenomenon occurring now. I looked at the CPI last year and saw that physician fees actually rose at a lower rate than the CPI in general.

So we disagree on those basic assumptions.

We also think that the management of the geographic distribution problem can be managed in different ways partially through the service corps, partially through debt forgiveness programs and partially in recognizing that there is an outward migration of physicians, whether they be called specialists or not, into smaller and smaller communities, and that we should not detract or disturb a phenomenon that is working in the national interest at the moment.

Senator **METZENBAUM**. Thank you.

Dr. Mann.

Dr. **MANN**. I believe that the administration bill would have a direct effect on schools of dentistry. It would hurt most where the problem is the greatest, and that is with the minority applicants, particularly coming from a rural State, Mississippi; our thrust is to attract people from lower income groups into the school of dentistry.

Dentistry has traditionally been a profession in which there is so-called upward mobility. About 40 percent of our students come from families whose income is $20,000 or less. So this would hurt us particularly and one dental school has simply passed on the loss of capitation support directly into tuition increases. Tuition expenses for dental students is getting out of hand.

In addition to tuition costs for dental students, they have the unique problem of having to buy instruments which cost $2,500 in the first and second years. Our applications to dental schools were down about 14 percent in 1977–78. This year they are down about 11 percent.

Among the number of people applying to dental schools, the chances of getting in are 1.6, 1.7. So it is becoming sort of an elitist profession, and I hate to see that develop.

Senator **METZENBAUM**. Thank you very much.

The Chair has agreed with Senator Schweiker as to the amount of time that we would each have for questions. My time has expired.

Senator Schweiker.

Senator **SCHWEIKER**. Thank you, Mr. Chairman.

Dr. Stemmler, my bill proposes to use the HPSL program loan income which would be no less than $16 million per year and redirect it in the loan forgiveness program, and my question is does the AAMC have a position on the value of loan forgiveness programs, both as it applies to first year students and to doctors entering practice in underserved areas?

Dr. **STEMMLER**. I think the AAMC position would be that we support the concept of loan forgiveness. We tend to discard the past experience, the past decades, because the debts that were borne by students during that particular era certainly are quite small relative to the magnitude of debt that is now being borne by students moving out. So that the notion of repayment by loan forgiveness for services is certainly compatible with the AAMC's position.

Senator **Schweiker**. In the last health manpower bill, which I cosponsored, we authorized capitation for medical, osteopathic, and dental schools of $186 million in fiscal year 1979, and $196 million in this fiscal year. Despite my best efforts, and you heard me describe them earlier, Dr. Stemmler, we got defeated in the Committee. The Chairman opposed it and we got beat significantly on the Senate floor.

From the $196 million that we authorized this year, we only appropriated $96 million in 1979, and this year we have only appropriated $69 million. You may have heard, and I am sure you know there is a rescission pending from the administration to wipe that out.

So if we accept the rescission and in this climate I am afraid our battle is going to be very difficult not to, it looks like we will have zero. So I guess my question is why does the AAMC believe that a new capitation like program would do any better in obtaining funding in view of our track record?

Dr. **Stemmler**. I think the AAMC understands that the notion of capitation certainly, if not dead, has been severely damaged. It strikes us though that it is very important for us to state our position that we believe our institutions have been and will continue to be the most available institutions for social change in health services available to the Federal Government. I think we have a history of behaving responsibly and I would predict that we will behave responsibly in the future, and I will say again that it seems to me that it is shortsighted on the side of the administration to take a position that for the small amount of money relative to total budget that enables institutions to be responsible should be withdrawn. That, I assert is not in the public interest.

Obviously, we are very grateful for the positions that you personally have taken to facilitate this support and we recognize the current environment.

Senator **Schweiker**. I think what disturbs me is 2 years ago, we led the fight in the Appropriations Committee, we did win the battle. But 3 months later they came in with a rescission and fought the same battle over again and we lost. So it is a continuing war and, unfortunately, we have been on the losing side in the last three battles, and that is why I asked the question.

Nowhere, Dr. Stemmler, in your statement does it say that your association prefers new legislation this year or a 1-year extension. My question is what is the AAMC's position on that issue?

Dr. **Stemmler**. We are strongly supportive of the initiatives that have been taken on the majority and minority side to have new legislation and we are testifying in support of that. Obviously, we have to support what is in the national interest and it seems to me we have to defer to the wisdom of the Congress in that regard.

But we are standing here today testifying in support of actions that you and your staff have initiated and which are now being brought before these hearings.

Senator **Schweiker**. Thank you. That is all I have.

Senator **Metzenbaum**. Senator Javits.

Senator **Javits**. Yes. Thank you very much, Mr. Chairman.

Mr. Chairman, I will just say about my general statement, preliminary to the hearings, that I hope that we will give also a good deal of attention to the allied health professions by way of this bill as we are doing to the highly professional groups which are represented here today.

I think the tendency of Americans, as care gets more expensive, will have to be to engage in degree of specialization, a high degree of specialization, and I think the utilization of less than the top professional group to do everything, is like in New York City when we took policemen off desk work, or at least many of them, and introduced policewomen exactly for that purpose. And it seems to me that there is a greater opportunity in the professions.

The only way we are going to accomplish this is by bucking up those elements which represent other practitioners not as highly trained, who can do so much of what the doctors traditionally have done because it was easy and pleasant. The patient likes it, I am sure, but it is highly unproductive use of such high professionals.

Senator **Metzenbaum**. We will certainly hear from some of those health agencies Wednesday.

Senator **Javits**. Just serving notice, and I hope my colleagues will indulge me as we search through that educational system and see what we can do that might help us a great deal in the cost of medical care.

I would like to ask the witnesses about this very, very grave problem, especially Dr. Stemmler, in respect to these foreign medical grants. I appreciate your feeling and position. I note what you say.

We ought to find a better way, but the fact is that we are some ways from finding a better way; the fact is that in areas which you have to see to believe in the great urban cities, they look like bombed out segments of London which I saw in World War II, and the service just is not there.

It makes it much more difficult for the FMG, in view of the already difficult situation. I hope you will not take it invidiously. I do not mean it invidiously for me or anybody else of the human. It just cannot be done.

What I hope very much, if I may make a suggestion, because your opinion on this will be very important, is to review it from two points of view.

One, the phasing period: What is important? I deeply believe that we now have enough notice about the facts that this program can be phased out much more effectively—I realize that you feel that you would be given an extension that means they would not do anything about it. I do not think that is so because the phasing period can be made pretty tight—and maybe cut down even shorter than the 5-year period that we now have. That is one.

And, two, if you would think in terms of what you can do to help us. Don't just tell us you are wrong, you should not continue this practice. People, even if they are poor and depressed, are entitled to better care, the same as other Americans. I could not agree more. But we have a condition, not a theory or even a principle, and so respecting any comment, Doctor, as I said, I beg of you to do two things. One, consider a revision of the authorization in terms of perhaps tighter phasing and, second, think through what you can do to help us, more than by just telling us to be disciplined, which we cannot be under the circumstances.

Dr. STEMMLER. Senator Javits, I certainly would not want to appear insensitive to the major problem that is faced in your community. I think what the association is trying to address is whether the remedy that is proposed is in the total best interest of providing services to those individuals who need them. Let me be specific. That relates to the extension of the requirements that the visa qualifying examination be passed before that foreign physician is allowed to take training in the United States.

Ninety-five percent of Americans can pass that examination. Yet, what we are proposing in this legislation is that the foreign national not be required to pass that exam. It sets up a belief that there should be a major difference in the competence of the provider of service to the individuals who are in need. There is just no way that the association can take a position supporting that notion.

I certainly accept your point and I believe it is worthwhile for us to consider what might be alternative solutions. I think there is a rich resource within the association to look at the problem along with you or individuals that you would like to have identified with whom we could work. But I think the mechanism that is proposed here, just on educational grounds, and the quality of service grounds, is one to which we must take exception.

Senator JAVITS. Well, would you be good enough then to submit some supplement? Could you do that, say, in a week, 10 days, what?

Dr. STEMMLER. I believe a week.

Senator JAVITS. Ten days?

Dr. STEMMLER. Yes.

[The following was received for the record:]

aamc association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

April 1, 1980

Senator Jacob Javits
United States Senate
Washington, D.C. 20510

Dear Senator Javits:

At the recent hearings held by the Senate Subcommittee on Health and Scientific Research of the Labor and Human Resources Committee on Monday, March 10, 1980, you requested that the Association of American Medical Colleges study further the problems addressed by some of the Sections of S.2378, the Health Care Management and Health Care Personnel Distribution Improvement Act of 1980, dealing with changes in the immigration laws relating to the entrance into the United States of alien foreign medical graduates (FMGs). Your concern centered around the problems faced by hospitals that rely heavily on FMG house officers and that apparently will be unable to attract sufficient numbers of either graduates of U.S. medical schools or alien M.D.s able to meet the more stringent requirements imposed by P.L. 94-484, most especially the requirement that they pass the Visa Qualifying Exam (VQE).

You requested that the AAMC address itself to two issues: (1) a continuation of the substantial disruption waiver, perhaps for a shorter time period than that provided for in S.2378; and, (2) alternative solutions to the problem of obtaining sufficient manpower to meet the health care requirements of urban hospitals.

Limited Extension of the Visa Qualifying Exam (VQE) Waiver

The Association, as it indicated in the statement it submitted to the Subcommittee on Health and Scientific Research of the Senate Labor and Human Resources Committee, is not unmindful of the problems anticipated by some hospitals, particularly those publicly run and located in urban areas, in attracting sufficient numbers of residents to fill openings in certain programs. However the AAMC, after careful reconsideration, has decided, for the following reasons, that it cannot, in good conscience, support a waiver of the VQE requirement in any form.

- The hiring of alien physicians unable to meet the current minimum legal requirements would result in the provision of substandard medical care. It has been contended that an inadequately trained physician is better than no physician at all; that may or may not be the case, but the truth of such statement need only be examined if there exists no other choice of service provider. The Association respectfully submits that this is not the case---if these institutions were given some financial or other assistance.

- The proposal to extend the substantial disruption waiver process implies that the purpose of a residency program is to provide service, ignoring the fact that the fundamental raison d'etre of a residency program is educational. Residents are important participants in our system of medical education. They both receive education from more senior residents and from fully trained attending faculty physicians and, at the same time, assist in the training of more junior house staff and, depending on the nature of the hospital's affiliation with a medical school, medical students. The solution offered by the use of waivers would undermine the quality of education offered and ultimately worsen the very problem it is designed to address. Medical school graduates applying for residency positions are primarily concerned about the quality of education and training offered by a given program. The presence of poorly trained upper-level residents can only serve to lower the quality of a program and thus its attractiveness.

The primary purpose of residency programs is educational. In the course of their education, residents, by participating in patient care under supervision, do contribute to an institution's provision of care to those whom it serves. However, because education is primary and quality graduate medical education requires that residents be amply prepared before entry, legislation to continue permitting entry of foreign graduates who cannot meet the achievement standards of the Visa Qualifying Examination would be sound neither educationally nor medically.

Alternative Solutions

The root causes of the difficulties encountered by public urban hospitals in attracting sufficient numbers of residents lie in the serious social problems of poverty and the economic decline of many of our cities. The long-term solutions to these problems are not within the capacity of the hospitals to solve. They must, however, try to deal, in the short term, as competently and humanely as possible with the enormous problems of disease and disability that press across their thresholds. Steps to improve the financial health of these institutions would contribute importantly to solving the problem of attracting qualified physicians to participate in residency training programs. It should be recognized that prudent young physicians are justifiably unwilling to embark on a three year graduate medical education program, undertaken to meet the requirements of the specialty boards of the American Board of Medical Specialties, in a hospital known publicly to be in such dire financial straits that its doors may be closed in three weeks, let alone three years. The plight of these institutions, which provide much of the health care for our poor and near-poor citizens, has recently been called to public attention by a thoughtful and thorough report, The Future of the Public General Hospital: An Agenda for Transition, produced by the Commission on the Public-General Hospital.

The problem has also been the focus of hearings held by the House Ways and Means Committee Subcommittee on Health. This Subcommittee is considering modifications to current Medicare/Medicaid reimbursement policies that impact adversely on public general hospitals. Among the recommendations made to the Subcommittee for changes in the current law to make the system more equitable were: (1) broader interpretation of "reasonable" cost for Medicaid reimbursement to cover the actual costs hospitals incur for outpatient services---public hospitals provide considerable outpatient health care for their communities and at present are poorly reimbursed for these services; and, (2) expanding reimbursement to pay for a proportion of bad debts and uncollectable accounts experienced by hospitals---particularly important for some urban hospitals that provide services to large numbers of illegal aliens not eligible for Medicaid coverage.

Allocation of funds under Title XVI of the Public Health Service Act, which provides for special project support to modernize medical facilities, would also help these hospitals, many of which desperately need to replace outdated and aging physical plants. Such improvements are especially important to attract qualified medical school graduates, who are understandably reluctant to limit their educational opportunities by obtaining their training in an outmoded facility.

The situation in which public urban hospitals find themselves today may be yet worsened, due to the desire to balance the Federal budget for the coming fiscal year, primarily at the expense of social welfare programs, and especially with President Carter's stated intention to reduce state and/or city revenue sharing. Any decrease in these flexible funds is likely to result in local governments encountering even greater difficulties in adequately supporting their medical care facilities.

There are actions which can be taken to directly address the problems facing public hospitals because of recently stiffened immigration laws. The short-term need is for physicians and, perhaps, other health care personnel to provide needed patient care currently given by alien medical graduates. A short-term approach to this problem is the provision in S.2378 for the use of National Health Service Corps physicians to fulfill their service obligation by serving as faculty or attending staff in such hospitals. S 2378 would extend the definition of health manpower shortage areas to clearly permit the assignment of such individuals to public general hospitals which have had to rely upon foreign medical graduates. As in the case of extending the substantial disruption waiver mechanism, no additional expenditure of Federal money would be required, but unlike that alternate solution, medical services would be provided by individuals whose competency in language and medicine is not in doubt. The provision of S.2378 modifying the definition of shortage areas is supported by the Association.

A second alternative would be a grant program for such distressed institutions, to permit them to hire additional attending staff as well as alternative health care providers such as physicians assistants and nurse practitioners. The additional cost of hiring attending staff might to some extent be offset by the higher productivity of fully trained physicians. Such a grant might include money for the training of para-professionals to assume some of the functions ordinarily assigned to resident physicians.

Such efforts, however, can only be viewed as stop gap measures, and over the long-term the real solution to the health service delivery problems resulting from the changes in immigration laws is the improvement of the quality of graduate medical education offered by these public general hospitals. In a study sponsored by the Human Resources Administration of the Department of Health, Education, and Welfare,* improvement of the quality of medical training programs was one of the few proposed solutions that was considered to adequately address the potential manpower problems due to restrictions on entrance of FMG's into the United States contained in the 1976 law. Comparisons of recruitment results in different specialty residency programs in the same hospital show the correctness of this assertion. In the same hospital, some residency programs have been able to recruit U.S. medical graduates for residency positions while other programs continue to attract few U.S. graduates. Because the differences are observed in the same hospital, it is clear that the difference in recruitment results are not a result of hospital physical plant, socioeconomic characteristics of patient population, neighborhood area or type of hospital ownership. The differences in such results reflect individual clinical department commitments to innovative leadership, improved staffing and a heightened educational emphasis. These factors appear to be the variables which affect the program's attractiveness.

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*Identification of Special Efforts of Title VI Restrictions on Selected Hospitals and Implications for Health Manpower. Urban Systems Research Engineering, Inc.

The Association is willing to work with the schools to assist them in any way it can in an effort to improve their graduate medical education programs. However, solutions of this character may well require substantial financial assistance to defray the additional costs of hiring new faculty at all levels, of providing better support services such as laboratory services and of expanding in-house educational programs.

The Association appreciates this opportunity to amplify its views on the subject of foreign medical graduates, and hopes that you will find them useful in evaluating proposed legislation in this area.

Sincerely,

John A.D. Cooper, M.D.

Senator JAVITS. Now, the other thing is, of course, you also cracked down on the state of professionalism at which we can bring new people in. I notice you oppose that, too.

Now, again, we are caught between the need and the millstone.

Dr. STEMMLER. I believe we supported the position that National Health Service Corps scholarships recipients should be able to provide their services in the areas of need, including the inner-city hospitals that are now heavily staffed by foreign physicians.

We also support the extension of the training periods for qualified foreign nationals to enable them to assume full credentials and qualifications. We feel that is appropriate.

Senator JAVITS. Yes. But you see it is the fact that there is a good deal of competition for residencies and we have to find an inducement. We cannot have it—you cannot get caught on that end, too. We have to have an inducement to bring them in.

Dr. STEMMLER. Senator Javits, I guess we take the position that a residency is a period of education and ought to be of sound educational quality.

Again, I do not think you and I are going to be able to settle what is a terrible problem, which we recognize in this brief interchange, but we certainly express our willingness to work with you to help.

Senator JAVITS. I think your colleague wishes to say something but before we do that, could we then extend your supplement to include this problem as well. You may make any suggestions that you can to help us.

Dr. COOPER. It is important to note that in where there is currently difficulty in recruiting the same hospitals, residents in pediatrics, there has been a turnaround in the internal medicine program. The internal medicine program's recruiting a number of U.S. graduates or qualified foreign medical students. No matter how you look at it, it is going to take some money. The pediatrics, program really suffers because there is not an educational program which you could entice a student to enter. The period of residency is an important part of a physician's education and U.S. graduates are seeking quality programs.

There are too few attending. The services are not properly organized, and the students are very bright. They understand this. Yet in internal medicine, in those same localities, they have done a good job in turning around the programs and consequently are attracting U.S. residents in the psychiatry program has been successful. They also have fewer foreign medical graduates in psychiatry than psychiatry programs nationally. It can be done but it is going to take some work within the institutions to make them attractive.

Senator JAVITS. Well, my time is up.

If we may, we would like to confer with both of you gentlemen with a view toward the practicality of these measures.

Thank you, Mr. Chairman.

Senator SCHWEIKER. One last question to each of you.

What is the total cost of tuition and room and board at each of your schools? If you can give us a quick figure, room and board.

Maybe, Dr. Stemmler, could you lead off with that?

Dr. **Stemmler**. We are budgeting next year at about $8,700 for tuition and living expenses at about $6,000. So, round numbers $15,000.

Senator **Schweiker**. Dr. Moore?

Dr. **Moore**. Tuition in osteopathic colleges ranges from a low of $300 a year to a high of currently of $9,000 a year. It is anticipated that a student graduating today is going to be indebted to the tune of roughly $60,000 to $70,000.

Senator **Schweiker**. And Dr. Mann?

Dr. **Mann**. At our school, as a State-supported school, resident tuition and fees comes to about $4,000 per year, but for all schools in the United States it is approximately $9,000. That does not include living expenses.

Senator **Schweiker**. What do you estimate for your living expenses at your school?

Dr. **Mann**. I would probably say about $7,000 a year at least, room and board.

Senator **Schweiker**. Thank you.

Senator **Metzenbaum**. Thank you very much, gentlemen. We appreciate your being with us this morning.

Our next panel consists of Dr. James E. Bates, president, Pennsylvania College of Podiatric Medicine, representing the American Association of Colleges of Podiatric Medicine; Dr. Henry B. Peters, O.D., dean, University of Alabama School of Optometry, representing the Association of Schools and Colleges of Optometry; Dr. Christopher A. Rodowskas, Jr., executive director, American Association of Colleges of Pharmacy; and Dr. Edward C. Melby, dean, New York State College of Veterinary Medicine, representing the Association of American Veterinary Medical Colleges.

Senator **Schweiker**. I again want to welcome Dr. Bates, a fellow Pennsylvanian and a distinguished educator.

Senator **Metzenbaum**. Any discrimination in favor of Pennsylvania is purely——

Senator **Schweiker**. We are just a medical leader, that is all.

Senator **Metzenbaum**. Dr. Bates, why do we not start with you.

STATEMENTS OF JAMES E. BATES, D.P.M., PRESIDENT, PENNSYLVANIA COLLEGE OF PODIATRIC MEDICINE, REPRESENTING THE AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE; HENRY B. PETERS, O.D., DEAN, UNIVERSITY OF ALABAMA SCHOOL OF OPTOMETRY, REPRESENTING THE ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY; CHRISTOPHER A. RODOWSKAS, JR., PH. D., EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY; AND EDWARD C. MELBY, D.V.M., DEAN, NEW YORK STATE COLLEGE OF VETERINARY MEDICINE, REPRESENTING THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES, A PANEL

Dr. **Bates**. Thank you, Mr. Chairman, Senator Schweiker.

My name is Dr. James E. Bates, and I am President of the Pennsylvania College of Podiatric Medicine. The Pennsylvania College is one of the five independent colleges of podiatric medicine which educate this Nation's entire supply of podiatrists. The other schools are located in New York, Cleveland, Chicago, and San Francisco.

I am pleased to have the opportunity to comment on both Senator Kennedy's and Senator Schweiker's proposals for reshaping our national policy regarding health manpower. I compliment each of the Senators and their staffs on the excellent work so clearly evident in each of these bills.

The challenges facing podiatry in the 1980's are unique among the health professions. Unlike our colleagues in the other health disciplines, we are part of a profession that remains critically undermanned. Additionally, podiatry remains the most seriously maldistributed of all the health professions. Finally, podiatry continues to suffer because many people do not recognize that we are a primary care discipline rather than a specialty.

We feel that the bills which are the subjects of today's hearings represent a serious attempt to address the problems involved in assuring foot health care for the American people. We are gratified that both Senator Kennedy's and Senator Schweiker's bills recognize the continuing need for institutional support for schools of podiatric medicine. Our schools are currently operating at full capacity and even so we face a serious shortfall of graduates. Some expansion of our operation is clearly necessary, yet non-Federal funding for such activities is very scarce. The States in which our schools are located are understandably reluctant to provide substantial support for institutions which address national rather than State needs. Further, student tuitions now account for half the cost of podiatric medical education, a higher percentage than for any other health profession. Clearly, the Federal Government alone has the incentive and the leverage necessary to expand podiatric medical education to the level needed to meet this country's need for podiatric services for the eighties.

Generally, we feel that Senator Kennedy's institutional support program is workable and correctly focused. Our colleges would be pleased to cooperate in meeting the national priorities set out as conditions for support. We question, however, why there is such a discrepancy between the basic per-student support for podiatry compared with the support proposed for the M.O.D. primary care disciplines. In terms of length and cost of education and in terms of the focus of instruction on comprehensive primary care, podiatric medical education is very similar to the other primary care professions. Yet the basic support formula for podiatry leaves us with the nearly impossible challenge of providing an equal education with far fewer resources. We urge the committee to authorize institutional support for podiatry at the same level as the other primary care professions.

Senator Schweiker's institutional support program recognizes clearly some of the problems and solutions involved in providing podiatric care equitably and fully. However, we feel that the support levels are inadequate.

Senator Schweiker's focus on remote site training of health professionals would undoubtedly go far toward alleviating our chronic maldistribution problem. In podiatry our experience is that 50 percent of our graduates eventually practice in the same States in which they are educated.

We are very pleased with the recognition by both Senator Kennedy and Senator Schweiker of the need for startup assistance for new schools of podiatric medicine.

I am going to skip along, Mr. Chairman. I would like to acknowledge that the student assistance proposals will help, and one of the things we have to recognize is the fact that the huge debt that the students are graduating with has to be considered when we talk about cost containment because they have to pay them back, and who else is going to pay them but the patients?

Podiatry is a primary care profession and, Mr. Chairman, I would like to submit the entire statement for the record.

[The prepared statement of Dr. Bates follows:]

Testimony of

Dr. James E. Bates, President
Pennsylvania College of Podiatric Medicine

on behalf of
The American Association of Colleges of Podiatric Medicine

Hearings on Renewal of Health Manpower Legislation

Subcommittee on Health and Scientific Research

Senate Committee on Human Resources

March 10, 1980

Testimony of Dr. James E. Bates, D.P.M., President of the Pennsylvania College of Podiatric Medicine, before the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources, hearings on health manpower legislative renewal, March 10, 1980.

INTRODUCTION

Good morning. I am Dr. James Bates, President of the Pennsylvania College of Podiatric Medicine. The Pennsylvania college is one of the five independent colleges of podiatric medicine which educate this nation's entire supply of podiatrists.

I am pleased to have the opportunity to comment on both Sen. Kennedy's and Sen. Schweiker's proposals for reshaping our national policy regarding health manpower. I compliment each of the senators and their staffs on the excellent work so clearly evident in each of these bills.

The challenges facing podiatry in the 1980's are unique among the health professions. Unlike our colleagues in the other health disciplines, we are part of a profession that remains critically undermanned. Additionally, podiatry remains the most seriously maldistributed of all the health professions. Finally, podiatry continues to suffer because many people do not recognize that we are a primary care discipline.

INSTITUTIONAL SUPPORT

We feel that the bills which are subjects of today's hearing each represents a serious attempt to address the problems involved in assuring foot health care for the American people. We are gratified that both Senator Kennedy's and Sen. Schweiker's bills recognize the continuing need for institutional support for schools of podiatric medicine. Our schools are currently operating at full capacity and, even so, we face a serious shortfall of graduates. Increasing the numbers is clearly necessary, yet non-federal funding for such activities is very scarce. The states in which our schools are located are understandably reluctant to provide major support for institutions which address national rather than state needs. Further, student tuitions now account for half the cost of podiatric medical education, a higher percentage than for any other health profession. Clearly, the federal government alone has the ability and the leverage necessary to increase the numbers in podiatric medical education to meet this country's needs for the 80's.

Generally, we feel that Sen. Kennedy's institutional support program is workable and correctly focused. Our colleges would be pleased to co-operate in meeting the national priorities set out as conditions for support. We question, however, why there is such a disparity between the basic per-student support for podiatry compared with the support proposed for the other primary care disciplines. In terms of length and cost of education and in terms of the focus of instruction on comprehensive primary care, podiatric medical education is very similar to the other primary care professions. Yet, the basic support formula for podiatry leaves us with the nearly impossible challenge of providing an equal education with far fewer resources. We urge the committee to authorize institutional support for podiatry at the same level as the other major primary professions.

Sen. Schweiker's institutional support program recognizes clearly some of the problems and solutions involved in providing podiatric care equitably and fully. However, here again we feel that the support levels are inadequate.

Sen. Schweiker's focus on remote site training of health professionals would undoubtedly go far toward alleviating our chronic maldistribution problem. In podiatry, our experience is that 50% of our graduates eventually practice in the same states in which they are educated.

We are very pleased with the recognition by both Sen. Kennedy and Sen. Schweiker of the need for start-up assistance for new schools of podiatric medicine.

The priority assigned by Sen. Schweiker to funding new schools of podiatry which will engage in interdisciplinary training with schools of medicine or osteopathy is based on very sound reasoning and recognizes the need for team approach training of health professionals as well as the delivery of health services. We stand ready to cooperate in this endeavor.

We are greatly encouraged by the emphasis in both bills on post graduate education and on interdisciplinary training. We believe that special project grants for clinical training of our graduates which could be awarded both to schools of podiatric medicine and clinics who choose to affiliate with us for purposes of graduate podiatric medical education, will help overcome the current critical shortage of training positions as well as promote interdisciplinary training.

STUDENT ASSISTANCE

The service contingent scholarship program proposed by Sen. Kennedy would help to eliminate podiatric manpower shortage areas. As I mentioned earlier, the problem of maldistribution is a critical one in podiatry. The department of HEW has identified some 1400 podiatric manpower shortage areas nationwide. This is a larger total than for any other health profession. According to the Department, fully 50% of all podiatrists practice in just five states.

The HEAL program revisions contemplated by Sen. Kennedy's bill are also necessary and appropriate. As was mentioned earlier, students of podiatric medicine bear a disproportionately large share of the cost of their education. The large loans incurred by our students will certainly do little to solve the cost containment problem.

The idea of special projects grants targetted to meet the needs of medically underserved areas is sound. Programs to recruit health professions students from underserved areas and to establish clinical and continuing education opportunities in such areas will undoubtedly be enormously helpful in dispersing health manpower more equitably in this country.

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS

Existing programs can also be utilized much more effectively to bring health care services to the underserved. We are gratified to see that Sen. Kennedy's proposal would make some very beneficial changes in the composition and function of the Corps scholarship program. On the other hand, Sen. Schweiker's plan to scale down the Corps scholarship troubles us greatly.

Students of podiatric medicine have only recently been participating in the National Health Service Corps scholarship program. With proper recruitment and orientation efforts, we feel that the scholarships program will be successful in providing quality health care in underserved areas. We are very excited about participating in this program and feel that its problems require correction by means of legislative and oversight activities of this Committee rather than by a phaseout of the program.

Although we have made some recent gains, there remains considerable resistance to increased participation by podiatry in the Corps scholrship program. In our opinion, this resistance stems largely from lack of knowledge about the role of our profession.

Podiatry is a primary care profession. The podiatrist provides comprehensive primary care for a specific portion of the human anatomy - in our case, the lower extremity. The podiatrist has a high index of suspicion for those systemic diseases which are manifested in the foot, e.g. diabetes mellites, peripheral vascular disease, arthritis, uremia and syphilis. I would also like to point out that the recent emphasis in our health care system on cost-effective ambulatory care brings the podiatrist into an even more central position, since the podiatrist's training is focused largely on assuring the ability to ambulate. The vast majority of podiatric care is provided in ambulatory care settings.

Podiatry therefore, like the other primary care profession, has a valid role to fill in the NHSC and HEW is beginning to recognize and support this view.

We are pleased that Sen. Kennedy has seen fit in his bill to expand the participation of non- MD's non- DO's in the Corps. We would suggest earmarking for podiatry a certain percentage based on the relative shortage of personnel compared with the other primary care disciplines.

TRANSFER OF PODIATRY TO THE DIVISION OF MEDICINE

Relative to the issue of primary care podiatry, one other point must be made. Consistent with the new found appreciation of podiatry's primary care role, our professional programs were administratively shifted, effective September 5, 1978, from the HEW Bureau of Health Manpower's Division of Associated Health Professions to the Division of Medicine. The profession supported this administrative transfer. There are many similarities among podiatry and the traditional medical professions, e.g. in the areas of educational background, of license to diagnose illnesses, prescribe drugs, perform surgery, and to admit and refer patients. We believe that this shift will facilitate a very constructive dialogue among the primary care medical professions.

It seems to us that any comprehensive renewal of the health manpower authorizations ought to take note of this administrative change in all appropriate instances. We urge you to amend, as necessary, and to legislatively recognize the placement of podiatry in the Division of Medicine. We will be happy to assist the Committee in every appropriate way in achieving this important objective.

This concludes my prepared remarks. I will be happy to answer whatever questions the Committee may have.

Senator **Metzenbaum**. Thank you very much. I appreciate very much your statement, Dr. Bates.

Dr. Peters, we will be happy to hear from you next, sir.

Dr. **Peters**. Mr. Chairman, Senator Schweiker, I am Dr. Henry Peters, dean, School of Optometry, University of Alabama, Birmingham, representing the Association of Schools and Colleges of Optometry.

The association's 13-member institutions in the United States are dedicated to training professionals necessary to meet the primary vision care needs of the American public. We represent a limited national resource and are vitally interested in the legislation under consideration today.

We are particularly impressed that both bills have addressed the need for adequate information and data collection.

While Senate bill S. 2144 provides authority for startup assistance, it is limited and would not support needed new school development in the view of the appropriation level that is authorized. We recommend a significant increase in this authorization, particularly for startup to meet the unique geographical needs of the profession of optometry. We recognize the public policy position regarding student support in the health professions. The availability of loans and of interest subsidy will make it possible for students to complete their education at their own expense.

Our students, however, are incurring ever increasing indebtedness and upon graduation are faced with further borrowing to establish or purchase a practice. This will have a major impact on the future geographic distribution of those students. Incomes for optometrists clearly do not come close to those that you were discussing earlier for physicians. With the average income for optometrists, for the first 5 years, of only $20,000, there is no possibility of them paying back the loans except by seeking the most lucrative positions, and this will prevent them from going to the very areas of service that I think we are all committed to.

Section 730 provides authority for special project grants. We find that to be quite acceptable and would be willing to work with new developments of those programs.

Optometry does support the concept of area health education centers, but to date we have not been included in this program even though we feel we have much to contribute and much to gain. We encourage the committee to establish specific incentives within the program for inclusion of optometry and other VOPP professions to insure the full development of the AHEC philosophy.

The special project grants, Senator Schweiker's bill, certainly would be strengthening to optometry education. The bill provides grants to States for service scholarships and we are supportive of this approach. In a recent paper developed by the Association of Schools and Colleges of Optometry on manpower issues, we strongly recommended that States play a role in meeting their individual health manpower shortages. To promote equity, States should be required to allocate such scholarship grants in relationship to the relative shortages of each health profession within the State, and this principle can also apply to the national health scholarships.

Section 708 of Senator Kennedy's bill provides for an effective data collection system. The changes in the construction grant authority which provide for ambulatory type facilities is considered highly beneficial and particularly for optometry education. We, too, are concerned with the interest obligations that our students would incur and urge that there be some subvention method in order to prevent an overwhelming debt that will not be productive to reach the targets that you have already established. This is particularly true in terms of the National Health Service Corps. They failed to address the unmet vision needs of these groups and optometry again, this year, even though we were included in the legislation, has been allocated no positions in the National Health Service Corps. We would like to see some consideration for allocation of such scholarships in accordance with the proportion of established shortage areas in each of the health professions.

Senator **Metzenbaum**. Will you wind up, please, Dr. Peters?

Dr. **Peters**. Yes, sir.

In summary, we recommend a continuation of startup assistance to recognize needs for additional schools of optometry; strengthening the incentives for practice in underserved areas; some specific changes in conditions for project grants and incentive awards program; incentives for AHEC participation by VOPP professions; loan interest subsidy to control indebtedness and the directed allocation of National Health Service Corps scholarships in accordance with relative shortage of each profession.

I have submitted a detailed paper and I hope I may have the opportunity to further comment at a later time.

Senator **Metzenbaum**. The entire statement will be included in the record.

[The prepared statement of Dr. Peters follows:]

TESTIMONY OF
HENRY B. PETERS, O.D.
OF THE
ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY
ON
HEALTH PROFESSIONS TRAINING ACT
(S. 2375, S. 2144)
TO THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

Association of Schools and Colleges of Optometry
1730 M Street, N.W.
Washington, DC   20036

(202) 833-3374

Good morning. I'm Dr. Henry B. Peters, Dean, School of Optometry, University of Alabama, Birmingham, representing the Association of Schools and Colleges of Optometry. The Association's 13 member institutions in the United States are dedicated to training professionals necessary to meet the primary vision care needs of the American public. We represent a limited national resource and are vitally interested in the legislation under consideration today.

We have reviewed the proposals in S. 2144 introduced by Mr. Schweiker on December 17, 1979 and S. 2375 introduced by Mr. Kennedy and others within the last week. It is our opinion that each bill represents a generally workable program. Each has strengths and weaknesses perhaps, but certainly contain significant improvements over existing legislation and address the present and future issues in the national interest.

In my presentation I would like to highlight aspects of each bill which we feel provide Federal impact to the benefit of the health of the people. At the same time we will suggest changes which in our opinion will strengthen the legislation and establish more effective Federal leadership in health manpower development.

Let me first address S. 2144.

The legislation recognizes that the key to identifying and determining changing circumstances in manpower need is based on adequate and timely information. The provision of authority to collect and analyze information is central to the effective exercise and balance of the other authorities of the proposal.

It is our opinion that the number of existing schools of optometry is inadequate to produce both replacement O.D.'s for an aging practitioner group, and to meet the manpower shortage. In addition, the class sizes of some of our institutions are straining the resources for effective clinical education. With only 13 schools there is also a significant geographic disparity and educational opportunity which needs to be addressed. While S. 2144 provides authority for Start-Up Assistance, it is limited and would not support new school development in view of the appropriation level authorized. We would recommend a significant increase in this authorization.

We recognize the public policy position regarding student support in the health professions. The availability of loans and of interest subsidy will make it possible for students to complete their education at their expense. Our students, however, are incurring ever increasing indebtedness and upon graduation are faced with further borrowing to establish or purchase a practice. Optometry has had the best geographic distribution in the past. Indebtedness, however, is forcing our graduates to locate in the most lucrative practice circumstances, and thus, potentially adversely affecting this balance. The loan forgiveness program in S. 2144 will not, unfortunately, provide sufficient incentive to alter this trend. With debts of $25,000 to $30,000 and practice establishment costs of $35,000, a loan repayment of $500/month for 24 months or $12,000 as provided for under Sec. 729, will not, on our opinion, meet the need to place practitioners in shortage areas. The inducements must be enhanced and the committee should consider repayment of a percentage of all Federal education loans for each year of service.

Section 730 provides authority for special project grants plus 20% of the grant amount when a school meets specified conditions. We are generally supportive of the concept in this program. However, while the needs of our schools are consistent, their individual ability to develop and carry out major grant projects may differ and thus the amount of "additional funds" available for educational innovations and improvements would be affected. A more consistent and predictable support program upon accomplishing national objectives is indicated. The special conditions to be met are generally considered reasonable. It should be noted, however, that a 10% tuition increase limitation is bothersome to the private schools of optometry in view of the fact that they have few other sources of income and inflation is running well over 10%.

Optometry supports the concept of Area Health Education Centers. To date we have not been included in this program even though we feel we have much to contribute. We encourage the Committee to establish specific incentives within the program for inclusion of optometry and other VOPP professions to ensure the full development of the AHEC philosophy.

Sec.'s 741, 748, 749, 750, 751, and 752 relating to grants for remote site training, clinical training, health care and economics, continuing education, educational cost control and curriculum development are especially welcome authorities. The issues addressed will contribute significantly to strengthening the educational program. It is difficult to predict whether the appropriation authorizations will be adequate to support programs in each of the health professions.

Sec. 760 of the bill provides Grants to States for Service Scholarships. We are supportive of this approach. In a recent paper developed by the Association of Schools and Colleges of Optometry on Manpower issues, we strongly recommended that states play a role in meeting their individual health manpower shortages. To promote equity, states should be required to allocate such scholarship grants in relationship to the relative shortage of each health profession within the state. We also encourage the inclusion of such a requirement in allocation of National Health Service Corps Scholarships. Again this year, the PHS has made the decision not to address the unmet needs and shortages of any of the VOPP professions. The vision care needs of the people are not being served.

S. 2375 was introduced by Senator Kennedy and others on March 4. This represents an extensive proposal which provides a degree of specificity and direction. There has been a temptation to do a comparative analysis of the two proposals. We have avoided that temptation in favor of dealing with each on its own merit.

Sec. 708 of S. 2375 provides for an effective and acceptable data collection, analysis and reports program which will allow for decision making to establish emphasis and de-emphasis of other authorities controlling the development and distribution of manpower resources.

The changes in the construction grant authority which provide for ambulatory primary care teaching facilities is considered highly beneficial. Support for this aspect of optometric education is needed.

In view of the increasing indebtedness and high interest rates, we are somewhat concerned with the interest obligation under the loan program. Payment of full interest during periods of education will be difficult. To defer the interest will result in even higher payments upon graduation. With first five year income for optometry averaging less than $20,000 and the high cost of establishing a practice, strain will be placed on resources and result in increased health care costs. We recommend a program element that would keep the interest payments during the period of training at 7% and perhaps be adjusted subsequent to completion of training.

We of course note that S. 2375 establishes a new loan program with interest subsidy in return for possible Federal service. Perhaps this program will receive sufficient support to nullify our concern. It does, however, require a service liability. We have no particular objection to obligated service but until regulations are promulgated, cannot judge the possible acceptance of the program by students. We would urge that the language provide for early decision on service and that uncertainty be avoided.

The NHSC has failed to address unmet vision care needs and implementation for comprehensive health service. This prompts us to request the committee to establish an allocation policy for the NHSC scholarship program. We urge you to consider allocation of such scholarships in accordance with the proportion of established shortages of each health profession. Sec. 751 should be amended accordingly. We are pleased to note that there have been added specific incentives for the practitioner to elect independent practice rather than Federal employment. We, along with others have been concerned with the increased operational cost of the NHSC program.

The Association of Schools and Colleges of Optometry is quite pleased with the new national priority incentive grant porgram. We do not know the origin or basis of the $150 formula for optometry and consider this to be too low. Certainly, if the cost of education is a factor the figure should be increased. We are pleased, however, with the approach to increases in the base upon meeting established objectives.

The objectives for optometry are generally acceptable and provide sufficient alternatives to allow for flexibility of individual schools. We do, however, feel that the 40% women enrollment is high. We have made significant strides regarding women in optometry but this level would be most difficult to achieve immediately. We recommend instead a percentage increase in each entrance class. We have previously spoken to the requirement of entering 25% or 50% out of state students. This is objectionable to many of our schools and the percentage should be lowered.

We have recommended programs to encourage more minority group representation in our student body. Sec. 787 is responsive to this need.

Sec. 788 of the existing legislation provides for Start-Up funds to assist new schools of the health profesions. S. 2375 would terminate that authority except for schools receiving support prior to October 1, 1980. We have already expressed our position on the need for additional schools of optometry. We recommended the continuation of Start-Up authority to encourage and assist in new school development where indicated.

Sec. 794 relating to Project Grants is most encouraging. The bill identifies some of the more important areas of optometric education which require special attention. We support its enactment and adequate funding. The same thoughts are expressed in support of Sec. 795. The containment of educational and health care cost is regarded as a high priority.

In summary, we are pleased to note that this bill addresses many of the health manpower issues discussed in our recent health manpower issues paper. We have made a copy of this paper available for the record.

We will continue to review these proposals and provide the Committee additional and perhaps more specific comments as the legislation proceeds. We most certainly urge this Committee to place health manpower legislation as a high priority.

In summary we have recommended:

- continuation of Start-Up assistance to recognize needs for additional schools of optometry
- strengthening the incentives for practice in underserved areas
- some specific changes in conditions for project grants and incentive awards program
- incentives for AHEC participation by VOPP professions
- loan interest subsidy to control indebtedness
- directed allocation of N.H.S.C. scholarship in accordance with relative shortage of each profession

Thank you. I'm available to respond to your questions.

Senator **Metzenbaum**. Dr. Melby, dean of New York State College of Veterinary Medicine, representing the Association of American Veterinary Medical Colleges.

Happy to hear from you, sir.

Dr. **Melby**. Thank you very much, Mr. Chairman, Senator Schweiker.

The Association of American Veterinary Medical Colleges appreciates this opportunity to express its views regarding continued Federal financial participation in health professions education.

I wish to describe the current status of veterinary medical education and provide our association's comments on the two bills before you.

Our statement, for the record, includes our goals for health manpower legislation. The statement contains some ideas for alternative or additional provisions which are not included in either of the bills.

Veterinary medicine is a biomedical science of such breadth that its numbers are now among those best equipped to deal effectively with the complex interrelationships among human beings, animals, and the environment. Veterinary medicine stands second only to human medicine in terms of the total contributions to biomedical research.

If society is to continue to benefit from advances in veterinary medicine, there must be no lapse in the quality of those trained to pursue it. Currently there are about 7,200 students enrolled in 24 colleges and schools of veterinary medicine in the United States. About 1,850 new veterinarians will be graduated this year. The cost of veterinary medical education ranks among the highest in the health professions, far beyond the amount that can be recovered from tuition or other usual sources of college income. Twenty-one of our colleges are in State universities and three colleges in private institutions where there is some State financial support. These States cannot be expected to continue to finance the major costs for veterinary medical education in the future.

Unlike their counterparts in human medicine, those responsible for training veterinarians must prepare their students to deal with complex health problems of not one but many species. They must do this without access to some major source of income available to medical schools. There are no third-party payer systems available to owners of animals requiring medical care. This results in severely limiting the service income of veterinary medical teaching hospitals.

With costs of veterinary medical education approaching $20,000 per year of training, it would be folly to presume that the students can carry the financial burden of their education. While physicians are often seen as able to command high incomes and therefore repay large educational debts, the situation for veterinarians is quite different. Starting salaries for our graduates average about $16,000.

To correct the present deficiencies and make it possible for the existing institutions to fulfill their regional responsibilities, to open the profession's doors equally to all qualified students, to insure that the profession benefits from the broadest possible base of good applicants, Federal sharing in the cost of veterinary medical education is absolutely essential. The unique role of the veterinary medical profession and veterinary medical institutions in the national health system necessitates adequate and equitable Federal financial support of veterinary medical education.

We appreciate the basic intent of the bills introduced by both Senator Kennedy and Senator Schweiker, for they indicate a desire to continue the Federal partnership in health profession education. We think that continued Federal participation is essential in veterinary medical education; however, while these bills propose that, neither proposes the extent of Federal participation that we believe is necessary.

We definitely favor the approach of Senator Kennedy's bill over that of Senator Schweiker's. This is because the former retains a system of institutional support which we believe to be a superior funding mechanism.

Institutional grants also provide a surer more stable funding source for the schools, which is critical for a rational utilization of the funds provided by both Federal and State governments.

The national priority incentive grants of Senator Kennedy's bill provide a basic system which, with some changes, could begin to meet the need in veterinary medical education. Such grants should provide potential funding of approximately 10 percent of the cost of education. This would suggest the need for a base of approximately $800 for each full-time student enrolled in 1981, with one-half times such amount for each of the criteria which are met by the schools.

The criteria should be revised somewhat if they are to be appropriately effective in meeting national objectives. We have proposed these revisions as we believe appropriate.

Since there are relatively few well-qualified underrepresented minority students currently enrolled in veterinary medicine, incentives for recruitment should be coupled with attainable goals. If the goal were set at an increase of 25 percent or four students per year, whichever is less, it would accomplish much more on a national basis. The bill as introduced contains a goal that is not realistically attainable.

Enrollment of students from States which do not have schools of veterinary medicine should be set at 20 percent or more, rather than at 30 percent. This would encourage greater participation in multi-State or regional education and would encourage greater service in the national interest.

Senator **Metzenbaum**. Would you please wind up, Dr. Melby?

Dr. **Melby**. Fine. We believe the criteria should extend to the problems of financial distress, educational assistance. Our annual cumulative loan debt for students is such that we do not feel that they could continue to carry this into their careers. We believe that the National Health Service Corps scholarship program, which is practically unknown in veterinary medicine, should be extended. The Health Services Administration shows a lack of interest in the valuable contributions which veterinarians can make. We believe that Senator Schweiker's proposal for health service personnel to interested States merits support and also that Senator Kennedy's proposed revision to section 753, which would make private practice more workable.

Finally, we believe in the area of construction and renovation of facilities, a waiver for continued student increases is necessary, and we do need subsidized loan guarantees for renovation of existing facilities.

[The prepared statement of Dr. Melby follows:]

STATEMENT OF EDWARD C. MELBY, D.V.M., FOR THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

I

Mr. Chairman and Members of the Subcommittee, the Association of American Veterinary Medical Colleges appreciates this opportunity to express its views regarding continued federal financial participation in health professions education. I am Edward C. Melby, Chairman of the Council of Deans of the Association of American Veterinary Medical Colleges and Dean of the New York State College of Veterinary Medicine at Cornell University. I speak today for the Association of American Veterinary Medical Colleges.

I wish to describe the current status of veterinary medical education and provide our association's comments on the bills before the subcommittee. At the conclusion of this testimony I have outlined the goals of our association for health manpower legislation. That portion contains some ideas for alternative or additional provisions which are not included in the bills.

A crossroads, perhaps a crisis, in veterinary medical education is upon us now. Demands for veterinarians and severe limitations on sources of income for veterinary medical schools are putting vital programs in jeopardy.

In the past few decades, startling changes have occurred in the veterinary medical profession. While the original and most obvious service, the delivery of direct health care to animals and the relationship of that service to food supplies and the nation's economy, remains a basic and vital function it is but one part of a larger responsibility. Thousands of veterinarians work for governmental agencies at all levels, helping to implement regulations designed to assure that only safe, wholesome animal products are marketed for human consumption. Others are involved in public health programs controlling such direct hazards to human health as transmissible animal diseases and dangers arising from toxins and environmental pollutants. Comparative medicine, that area of study which deals with the interface between animal and human medicine and is vital to advances in understanding and preventing disease, requires investigators trained in schools of veterinary medicine. If those on the front lines of veterinary medical activity are to have the knowledge and tools to perform effectively, research in the laboratories and in the field must be relentless and must be pursued by highly trained professionals.

Veterinary medicine is a biomedical science of such breadth that its members are now among those best equipped to deal effectively with the complex interrelationships among human beings, animals, and the environment. If society is to continue to benefit from advances in veterinary medicine, there must be no lapse in the quality of those trained to pursue it. Currently about 7,200 students are enrolled in twenty-four colleges and schools of veterinary medicine in the United States. About 1,850 new veterinarians will be graduated this year. Clearly, any significant reduction in the quality of training would impair a vital national resource. Nevertheless, several factors are threatening to do just that, foremost among them the financial squeeze.

The cost of veterinary medical education ranks among the highest in the health professions, far beyond the amount that can be recovered from tuition or other usual sources of college income. Twenty-one of the veterinary medical colleges are in state universities, and these states cannot be expected to continue to finance the major part of the nation's costs for veterinary medical education. Like schools devoted to training physicians, veterinary medical colleges maintain a high ratio of faculty to students, particularly in the clinical aspects of training; veterinary schools face high costs in recruiting and maintaining high-quality faculties; they must provide expensive laboratories and equipment for teaching the full range of biomedical sciences; and they must provide those vital arenas of instruction, modern teaching hospitals.

Unlike their counterparts in human medicine, those responsible for training veterinarians must prepare their students to deal with complex health problems of not one but many species. They must do this without access to some major sources of income available to medical schools. Most significant for animal health care, there are no third-party payer systems available to owners of animals requiring medical care. This results in severely limiting the service income of veterinary medical teaching hospitals. Income in such hospitals rarely provides more than half the needed support.

With costs of veterinary medical education approaching $20,000 per year of training, it would be folly to presume that the students can carry the financial burden of their education. While physicians are often seen as able to command high incomes and therefore repay large educational debts, the situation for veterinarians is quite different. Starting salaries average about $16,000 and have remained at about that level over several years.

The diminishing federal financial support of recent years and rapidly rising costs have increased the burden on the state governments and veterinary medical students. Current public concern over levels of state spending inhibits sufficient expansion of state appropriattions for veterinary medical education. To attempt to close the income-cost gap by further limiting the enrollment of out-of-state students would be tempting but shortsighted. Because of the geographic locations of the institutions, many states would be underserved, and entire regions of the country would be shortchanged.

To correct the present deficiencies and make it possible for the existing institutions to fulfill their regional responsibilities, to open the profession's doors equally to all qualified students, to insure that the profession benefits from the broadest possible base of good applicants, federal sharing in the cost of veterinary medical education is absolutely essential. The unique role of the veterinary medical profession and veterinary medical institutions in the national health system necessitates adequate and equitable federal financial support of veterinary medical education.

We appreciate the basic intent of the bills introduced by both Senator Kennedy and Senator Schweiker, for they indicate a desire to continue the federal partnership in health professions education. We think that continued federal participation is essential in veterinary medical education; however, while these bills propose that, neither proposes the extent of federal participation that we believe is necessary.

We definitely favor the approach of Senator Kennedy's bill over that of Senator Schweiker's. This is because the former retains a system of institutional support, which we believe to be a superior funding mechanism. Institutional grants entail lower administrative costs than the competitive and special projects grants, both for the government and the institutions. Institutional grants also provide a surer, more stable funding source for the schools, which is critical for a rational utilization of the funds provided by both federal and state governments. However, you will note throughout our comments that we have excerpted heavily from Senator Schweiker's bill in defining the program areas which should be national goals for veterinary medical education.

"The National Priority Incentive Grants" of Senator Kennedy's bill provide a basic system which, with some changes, could begin to meet the needs in veterinary medical education. Such grants should provide potential funding of approximately 10% of the cost of education. This would suggest the need for a base of $800 for each full-time student enrolled in 1981 with 0.5 times such amount for each of the criteria which are met by the school.

The criteria should be revised somewhat if they are to be appropriately effective in meeting national objectives.

- Since there are relatively few well-qualified under-represented minority students currently enrolled in veterinary medicine, incentives for recruitment should be coupled with attainable goals. If the goal were set at an increase of twenty-five percent or four students per year, whichever is less, it would accomplish much more on a national basis. The bill as introduced contains a goal that is not realistically attainable.

- Enrollment of students from states which do not have schools of veterinary medicine should be set at twenty percent or more, rather than at thirty percent. This would encourage greater participation in multi-state or regional education and would encourage greater service in the national interest.

- A criterion should be added to encourage and assist the expansion of programs of post-doctoral education in pathology, toxicology, and laboratory animal medicine and for careers in education and research. An increase of twenty-five percent in enrollment in such programs should serve to qualify a school under this criterion.

- A criterion should be added to encourage the improvement of clinical education through the expansion or planned expansion within one year of such resources as (a) a satellite clinical facility, (b) a new clinical specialty service or (c) a clinical facility to provide continuous emergency care services.

If these changes were made in Senator Kennedy's bill, it could provide appropriate financial support to the schools to permit them to continue to meet regional and national goals and improve the quality of their educational programs. If all of the schools participated, the cost would be approximately $16 million, rather than the $4.6 million proposed to be authorized for 1981.

Since there are relatively few qualified minority student applicants to veterinary medical schools, Senator Kennedy's proposed "Educational Assistance to Individuals from Under-represented Minority Groups and Disadvantaged

Backgrounds" offers vital and needed assistance in changing the present situation. Greater efforts are needed to identify potential health professions students early in their educational experience and help them attain their full academic potential. Such help should continue through the period of pre-professional education and should continue as special educational assistance in the professional education programs. We are concerned that efforts to recruit minority and other disadvantaged students into veterinary medical education without the capability to give special assistance to retain such students in the professional program is wasteful and counterproductive. Senator Kennedy's proposal would offer appropriate early assistance as well as much needed follow-through in the professional program.

Senator Kennedy's bill provides for continuing assistance for schools in financial distress and offers significant improvements over the present system. We believe it is essential that schools in financial distress develop plans and carry out managerial reforms designed to stabilize operations and terminate deficit spending situations. Senator Kennedy's bill appears to provide for that.

With respect to student loan programs, we must emphasize the fact that veterinary medical education is expensive to the institutions providing it and to the students. Veterinarians do not have high income potentials, particularly during the early years of their careers. As tuitions and living costs rise, more and more qualified students are deterred from a veterinary medical education because of inadequate finances. We are extremely heartened to see that both S. 2144 and S. 2375 contain realistic loan programs offering opportunities for interest subsidies and deferrals and loan forgiveness for service in priority areas. For many students from middle- and lower-income families, we fear the very real prospect of bankruptcy if there is not federal assistance with their educational debts.

In several places in S. 2375, there is a differentiation between medical students and veterinary students. Examples include the annual and commulative loan limits and the period of deferral of repayment for post-doctoral education. In view of the current nature and costs of veterinary medical education, we believe that any such distinctions are unwarranted.

S. 2144 provides for a deferral of loan repayment while a student is engaged in an accredited internship or residency program. This is inappropriate when applied to veterinary medicine. We are a small profession which has only recently begun to have the resources to operate separate accreditation programs for post-doctoral studies; only two disciplines are active in such accreditation now. The Kennedy bill language referring to "approved" programs would alleviate this problem.

We are very supportive of the programs of loan forgiveness for shortage area service provided in both bills. We believe that such a program is a highly cost-effective means of addressing the needs of medically underserved areas. Veterinary students eagerly participated in the program operated under P.L. 94-484. We encourage the subcommittee to emphasize this program as a major facet of the health manpower law.

In contrast, the National Health Service Corps (NHSC) scholarship program is practically an unknown quantity in veterinary medicine. Despite the large numbers of students and enormous sums of money that have been involved in the NHSC scholarship program over the years, only four scholarships have been awarded to veterinary students, and this was done only during the current academic year. We believe that the new authorization for this program should indicate the clear intent of Congress to include veterinary students at a meaningful level. At least 50 scholarships should be awarded to veterinary medical students annually, and 50 entry-level NHSC positions should be held for veterinarians in each year. This number of graduates could readily apply their knowledge of comparative medicine, preventive medicine, and communicable and parasitic diseases in community- and reservation-based health centers. Such applications of veterinary manpower have been recognized and utilized by the armed forces for years.

We would also add that we have found in the Health Services Administration a remarkable lack of interest in and understanding of the many valuable contributions which veterinarians can make to human health. In view of this, we would not be adverse to Senator Schweiker's proposal to transfer a substantial part of the responsibility for health service personnel to interested states. At the state level, we would anticipate that there would be a greater understanding of the health needs of the local population.

We have long believed that the "private practice" option under the NHSC scholarship program is particularly well suited to veterinarians. We support the changes that Senator Kennedy has proposed in Section 753 of the present law to make this option more workable. The idea of an income supplement during the first years a new practitioner is struggling to establish himself would be especially effective.

In the area of construction assistance for schools of the health professions, we wholeheartedly endorse the sections of S. 2144 and S. 2375 which provide (1) a waiver of any existing requirement for continued student enrollment increases, and (2) interest-subsidized loan guarantees for renovation of existing educational facilities. We also believe there is a continued role for a program, as provided in S. 2375, of at least some grants for construction of new facilities.

We support the provision of S. 2375 which would authorize the continuation of start-up assistance grants to new health professions schools which began participation under P.L. 94-484. There are also four additional veterinary schools in development which have made their plans in reliance upon a continuation of such assistance, and they deserve to receive this aid because of the added service they will provide to the states in which they are located.

It is of course difficult to compare the provisions for special projects grants of S. 2144 and S. 2375 because of the greatly different emphases on the program in the two bills. In general, both bills provide opportunities for the schools to undertake projects which would address major needs of veterinary medical education in the coming years. We would note, however, that the authorization for appropriations under Section 794 of S. 2375, apparently the major source of special projects in veterinary medicine, is far too low to provide a significant level of activity by the many schools which would be competing for these grants.

Moving away from the specific bills before the subcommittee, the goal of our association is to work toward a new health manpower education authorization which would contain the following features:

(1) Institutional support based upon student enrollment to accomplish specified national goals.

(2) Student financial aid through scholarship and loan programs, both of which could obligate certain professional service in the national interest.

(3) Financial assistance in construction and renovation of educational facilities.

(4) Financial incentives to attract minority students and assist in offsetting the costs of retaining them in the professional education programs.

(5) Financial support for certain special projects directed to the improvement of the quality of professional education and preparation for specialized careers critical to national goals.

(6) Institutional financial distress grants restructured to provide opportunities and motivation to move out of a deficit spending situation.

(7) Financial assistance in the initial period of start-up of new veterinary medical schools with preference given to those serving multi-state and regional needs.

Institutional Support Grants

An amount of $2,000 per student (10% of the annual cost of education per student) enrolled in the professional education program should be authorized for annual institutional support grants to schools and colleges of veterinary medicine which perform in the national interest, upon satisfaction of one of the following criteria.

(1) At least 20% of the enrollment of full-time, first-year students in the school is comprised of students who are residents of states in which there are no veterinary medical schools currently graduating students; or

(2) The school expands, or plans to expand within 12 months, its clinical educational resources by one of the following or comparable measures: (a) a satellite clinical facility to improve and amplify its clinical education programs; (b) a new clinical specialty service with at least two appropriately educated and experienced faculty members; (c) a clinical facility to provide continuous emergency care services; or

(3) The school increases by at least 25%, or plans to so increase within one year, the enrollment of post-doctoral students in the specialties of pathology, toxicology, or laboratory animal medicine, or in disciplines essential for careers in veterinary education and research.

Justification of Institutional Support Grants for the Specified Purposes

There are now twenty-four veterinary medical colleges in twenty-three states. Twenty-one are state-supported institutions, and three are components of private universities, in which case some state financial support is available. Since the twenty-three states provide the basic financial support of these schools, there is particular need to stimulate multi-state and regional educational opportunities through federal sharing of approximately 10% of the cost of education.

Veterinary medical colleges need additional financial resources to provide educational opportunities in the clinical specialty services and to provide facilities and services which will improve the entire clinical education program.

There is a very significant shortage of veterinary pathologists, toxicologists and laboratory animal medicine specialists to serve the requirements for evaluating health impacts of potentially toxic, carcinogenic and mutagenic agents, particularly the health impacts of such agents in model animals. There is also a shortage of qualified veterinarians for academic positions in teaching and research.

Student Financial Aid

A student financial aid program, including scholarships and loan programs, is proposed as follows:

1. Health Professions Student Loans

   A program of federally subsidized low interest loans should be continued and expanded. Such a program should include deferral of repayment obligations for up to five years of post-doctoral education and interest charges should not be the responsibility of the borrower until the professional education and any post-doctoral education are completed. Service in a designated underserved area should qualify as a loan repayment equivalent of $10,000 per year of service.

2. Exceptional Financial Need Scholarships

   A program of scholarships for students with exceptional financial need should be continued and expanded. Such a program should provide partial financial support during the first year of approximately 50% of the costs of education and maintenance, and a similar amount for each succeeding year of the professional educational program.

3. National Health Service Corps Scholarships

   A new National Health Service Corps Scholarship authorization should clearly indicate the intent of the Congress to include veterinary medical students in the scholarship program and veterinarians in the National Health Service Corps service programs. At least 50 scholarships should be awarded to veterinary medical students annually and 50 entry level National Health Service Corps positions should be held for veterinarians in each year of a new authority.

Justification of Student Financial Aid

Since the income potential of veterinarians is not high, certainly not comparable to the income potential of physicians, student aid should be structured to the realistic ability of the young professional person to repay either by service or in money.

Veterinarians could provide valuable clinical veterinary medical, preventive medical, and public health services in the National Health Service Corps, but the opportunity has not been offered. Only four NHSC scholarships have been awarded to veterinary medical students, and to date no veterinarians have served in the NHSC. Veterinarians would add a dynamic new dimension to the present health care teams of many community health care centers and would improve the economic base of many rural areas.

A loan program with relatively low interest rates should be continued to permit students to enter the veterinary medical profession when family or individual financial resources are inadequate to meet educational costs. Without such a program, many students of low and medium income families will have to give up goals of veterinary medical careers since veterinary medical salaries are inadequate to repay large loans at high interest rates.

Scholarships for exceptionally financially needy students are necessary to offer such students an opportunity for a veterinary medical education, but the program should be restructured to permit the student to continue through the professional program partially supported by the scholarship. The current program of one year of full support results in attracting the student for one year and then "dumping" the student into the hands of the high interest loan market or possibly forcing the student to drop out of school.

Financial Assistance Grants for Start-Up of New Institutions

A program similar to that authorized by P.L. 94-484 should be continued to assist those schools now in development to attain a fully-operational, quality program. The new authority should permit completion of commitments made under P.L. 94-484 to the veterinary medical schools at Virginia Polytechnic Institute and State University and Tufts University. It also should permit new awards to be made to developing schools, particularly those serving multi-state needs, which have, on the effective date of the new authority, a "statement of reasonable assurance" by the recognized accrediting agency. These developing schools are located at North Carolina State University, the University of Wisconsin, Oregon State University and the University of Nebraska.

These developing educational programs have been planned and construction funds have been appropriated on the belief that federal start-up assistance would be available for beginning faculty recruitment, purchasing expensive movable equipment, purchasing autotutorial resources, and beginning an appropriate library collection. Without such start-up support, these programs may have insufficient resources to provide a quality education.

Financial Assistance for Construction and Renovation of Facilities

Authority should be continued for the construction and renovation of educational facilities. Such authority should require matching of federal funds by at least 20% non-federal funds.

Increasing enrollments should not be a requirement of a construction or renovation grant authority, and requirements for increased enrollments applied to grants under P.L. 94-484 should be rescinded.

The facilities of several veterinary medical schools are inadequate for contemporary veterinary medical education and should be replaced or renovated. New facilities such as satellite clinical centers are needed by many of the schools to provide a sufficient range of clinical experiences.

Without the assistance of federal funds for these purposes, the states will not be able to meet the needs for adequate facilities, and without them some institutions will provide inadequate, poor quality education. Eventually some may lose accreditation as a result of inferior educational facilities.

Minority Student Enrollment Incentives

A new program for improving minority participation in veterinary education should be authorized. Since minority students may come from disadvantaged educational backgrounds, special programs designed to retain such students in the professional educational programs should be encouraged. Nothing will be gained through a program which attracts minority students unless it also provides incentives and resources to retain them through the program to graduation.

An appropriate authority for veterinary medical education would provide $10,000 per minority student year of education.

Special Projects for Educational Quality Improvement

A program of grants should be authorized to support and stimulate the improvement of educational quality and for innovative efforts to enhance educational experiences.

Projects eligible for such grant support should include:

1. Improvement of clinical instruction by the addition of new clinical services and facilities.

2. Development or expansion of programs for post-doctoral education in the currently under-supplied specialties of pathology, toxicology and laboratory animal medicine or for academic careers in teaching, research and service.

3. Enhancement of educational programs through the addition of satellite facilities and rural health team services or the improvement of education in health care delivery and animal and human nutrition.

Grants to Aid Schools in Financial Distress

Financial distress grnats authorized by P.L. 94-484 should be continued, but the program should be revised so that incentives would be provided to terminate deficit spending. Financial distress grants have been a vital factor in maintaining one of the veterinary medical colleges. That one must have further support, and others may need it. The present system of grant eligibility justification which requires evidence of continued deficit spending should be changed. Part of any continuing justification should be based on the presence of a plan of financial recovery and termination of the deficit spending situation.

We urge the subcommittee to accept our proposals for changes in and additions to S. 2144 and S. 2375, which are heroic efforts to address very vital and complex issues. On behalf of the Association of American Veterinary Medical Colleges, I thank the subcommittee for the opportunity to present our views.

Senator **Metzenbaum**. Thank you very much, Dr. Melby.

Dr. Rodowskas.

Dr. **Rodowskas**. Thank you, Mr. Chairman.

My name is Christopher Rodowskas and I am executive director of the American Association of Colleges of Pharmacy. We have 72 schools, including four in the great State of Ohio. I am a former Ohio State faculty member.

Senator **Metzenbaum**. I am glad somebody got on from Ohio.

Dr. **Rodowskas**. It has been estimated that one-seventh of all hospital days in this country are devoted to the care of adverse drug reactions, at an annual cost of $3 billion. Clinical training in our schools prepares the modern pharmacist to address this type of problem. As consultants in institutions clinically trained pharmacists have proven in study after study their cost-effectiveness in drug use. By eliminating duplications, by preventing interaction and by cautioning patients about dangerous side effects, these professionals prevent human misery as well as wasteful expenditures. A study of 19 hospitals indicated that clinical pharmacy services combined with a unit dose medication system could reduce overall costs by $1 per patient per day. Since Americans are hospitalized for about 275 million days annually potential savings could amount to $275 million per year if such services were adopted nationwide.

As community pharmacists, our clinically trained graduates are better able to help people select appropriate nonprescription medications, to substitute economical generic prescription drugs, to detect potential adverse reactions, and to direct patients to other health professionals when necessary.

As primary-care practitioners, pharmacists are increasingly becoming responsible for followup visits after a patient's treatment has been established by the physician.

Our clinically trained pharmacists are vital members of the geriatrics health care team. One reason for this is that drugs must be prescribed differently for the elderly than the average adult.

I could continue to the various roles that our pharmacists are involved in today, but I want to get to some specifics of the legislation that is before the committee and some interests that we have.

One of the things that we are requesting, that we have not asked for before, is a federally-supported pharmacy residency program. Right now, as health care has become more generalized, we have more of our graduates who want to continue their education a year or two beyond. Presently, very little support is available for programs of this type. We hope that some might become available.

Our detailed comments on S. 2375 and S. 2144 are contained in our longer statement.

Briefly, with respect to S. 2375, in the loan program interest rates for pharmacy students should be subsidized down to 5 percent because of low anticipated incomes. We have heard some of our veterinary friends complain about $16,000 a year incomes. I wish the pharmacists were doing that well.

Considerably more than $9 million should be made available for VOPP special projects. Schools with incoming classes of 10 percent minorities rather than 15 percent should be eligible for additional funding in sec. 772(i)(2)(A)(ii). I think there is a problem with Senator Kennedy's minority requirements simply because the geographic distribution of minorities is skewed. So why penalize schools in those States which do not have large minority populations?

Although the ideas are creative and generally excellent, in Senator Schweiker's bill, we find that there is a shortcoming in the lack of any institutional support.

Again we would look for Senator Schweiker's bill to provide greater student assistance.

We are aware of the pressures on the Congress to balance the budget next year and the cuts in health and education programs can be anticipated. Nevertheless, we believe pharmacy colleges have demonstrated that their contributions to public interest, both in human terms and in terms of cost containment, merit continued Federal support.

I am pleased to have this opportunity to present my views to you.

[The prepared statement of Dr. Rodowskas follows:]

STATEMENT BY THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY ON HEALTH MANPOWER LEGISLATION

US SENATE
COMMITTEE ON LABOR & HUMAN RESOURCES
SUBCOMMITTEE ON HEALTH & SCIENTIFIC RESEARCH

March 10, 1980

Christopher A. Rodowskas, Jr., Ph.D., Executive Director

Introduction

Our country's most recent "Forward Plan for Health" has identified cost containment, primary care and access to services as public policy priorities in the financing and delivery of health care. The American Association of Colleges of Pharmacy, a non-profit educational society representing the 72 accredited colleges of pharmacy in the United States, concurs that these priorities require immediate attention and believes they should be addressed through the cooperative efforts of health care providers, voluntary associations, educational institutions and government. At the same time, we urge a sustained effort and commitment to assure that these national health priorities are transformed into permanent characteristics of an ongoing public health policy and health-care delivery system. The economic viability of our nation and our citizens' right to health care demand no less.

Pharmacy, as an integral and vital component of health care, has made steady progress in containing health-care costs, improving primary care and assuring better access to services by improving the ways drugs are prescribed, dispensed, administered and used. Over the long term, the extent to which these contributions can be maintained and enhanced to their full potential depends almost exclusively on the content and quality of pharmaceutical education.

The dramatic transition in professional academic programs in pharmacy toward direct patient care in a clinical environment has significantly increased the cost of pharmaceutical education. In recent years, this increased cost has been offset by federal capitation funding requiring clinical orientation in the pharmacy curriculum. It is the strong conviction of the American Association of Colleges of Pharmacy that federal financing of pharmaceutical education must be continued in some form to assure that future pharmacy practitioners accelerate the profession's contributions in addressing national health priorities. Recognizing that continued federal financing must be justified through evaluative research on the impact of pharmacy practice as it relates to national health priorities, the Association has encouraged its individual members and member institutions to design and implement controlled field studies, including cost-benefit and cost-effectiveness studies, in an attempt to document pertinent pharmacy practice achievements.

Pharmacy Practice Achievements

Pharmacy practice achievements, as they relate specifically to cost containment, primary care, and access to health-care services, involve pharmacists' expanded roles in ambulatory, acute, and extended care.

One of the best examples of the cost effectiveness of the pharmacist in these roles is a pharmacist-conducted training program that teaches patients to self-administer certain parenteral medications at home. Selected patients of the Ohio State University Hospitals are trained to self-administer calcitonin, injectable analgesics, antihemophilic factor, cytarabine and parenteral hyperalimentation solutions, thus minimizing the cost of outpatient clinic, physician, or home nurse visits.(1) Financial data based on one year's experience with this program indicate that savings far outweigh costs. For one patient alone, a hemophiliac receiving Factor VIII, savings were more than $20,000 in the first year.(2) The pharmacists' professional services under this program are reimbursed by Blue Cross of Central Ohio; approval of such payment by a third party is viewed as a major step in recognizing the cost effectiveness of the pharmacist's clinical role. Other pharmacy programs to train patients in the home administration of total parenteral nutrition have been reported.(3)

Another example of reimbursement for clinical pharmacy services is a program in a medium-size community general hospital whereby third parties reimburse, on the basis of documented costs, for growth hormone home instruction, patient consultations and visits, and pharmacokinetic consultations by pharmacists.(4)

Several published reports indicate that pharmacists' therapy management or monitoring of patients with chronic diseases such as hypertension or diabetes may result in cost savings through improved treatment outcomes and better utilization of health-care personnel. One report described the effect of patient-oriented pharmaceutical services on treatment outcomes of diabetic patients who were randomly assigned to study and control groups.(5) Patients whose therapy was monitored and who were counseled by a pharmacist showed improved symptomatology, required significantly fewer changes in therapeutic regimen, and had a lower incidence of hospital admissions and physician contacts as compared to patients in a control group. In another study, patients with essential hypertension revealed significant improvement in knowledge of the disease, compliance with prescribed therapy, maintenance of blood pressure within the normal range, and the requirement of physician follow-up when clinical services were provided by a pharmacist.(6) A study funded by the National Center for Health Services Research and conducted at a Public Health Service Indian hospital determined the effectiveness of a pharmacist in the management of patients on long-term drug therapy. Working under detailed chronic care protocols and defined health parameters for specific chronic diseases, more efficient utilization of both pharmacists and physicians was achieved without sacrificing quality of care.(7) Although the three studies mentioned above did not specifically address cost savings, they suggest substantial savings through a reduction in hospitalization or physician visits.

In a cost-benefit study conducted in an outpatient clinic of a large medical center, the average prescription cost for patients who received only traditional pharmacy dispensing services was more than 2.5 times that for patients whose therapy was monitored by a pharmacist.(8) The difference in cost was attributed, in part, to the use of patient medication profiles, the selection of less expensive drugs when possible, and the elimination of drug duplications through coordination of therapy prescribed by more than one physician.

A report of a study in nineteen hospitals indicated that clinical pharmacy services combined with a unit-dose medication system could reduce overall costs by $.79 to $1.25 per patient day.(9) This finding assumes added significance when considering that the American public is hospitalized in short-term general hospitals for approximately 275 million inpatient days per year.

Participation by pharmacists in medical rounds in a 250-bed pediatric hospital resulted in cost savings of $.54 per patient day solely through elimination of medication waste due to late drug order changes.(10) Assuming 90 percent occupancy in this hospital, the total yearly savings would be nearly $45,000. In an unpublished study conducted at the University of California Medical Center in San Francisco, a clinically trained pharmacist who monitored total parenteral nutrition therapy in the surgical service of the hospital was able to effect a 24 percent cost savings, representing a net savings of $14,000 in one year.(11) Another report indicated that clinical pharmacy services were responsible for reducing the hospital stay, by one day, of 20 percent of 130 internal medicine patients.(12) By extrapolating the net cost of the pharmacists' services to a yearly basis, the savings for just the two internal medicine wards would be more than $20,000. A pharmacy program of discharge medication interviews in another university hospital resulted in substantial dollar savings for patients and was deemed to be cost beneficial.(13)

A study carried out in four skilled nursing facilities, one of which served as a control, demonstrated that clinical pharmacy services resulted in estimated savings of $80,000 per year for 300 patients ($.73 per patient day) through reduction in the use of inappropriate or unnecessary drugs and prevention of adverse drug reactions.(14) Clinical pharmacy services provided to 25 Medicaid patients in a skilled nursing facility in Washington state resulted in savings of about $6 per patient month through reduction of unnecessary drug use. Projected to all such facilities in the state, the net savings to the Medicaid program would be $747,000 per year.(15) Drug regimen reviews performed by pharmacists in six skilled nursing facilities and one institution for the mentally retarded resulted in a reduction of 0.9 to 2.44 prescription orders per patient per month. Extrapolation of the dollar savings to all Medicare and Medicaid skilled nursing facilties in the country would yield net savings of $3.2 million to $37.2 million per year.(16) Several reports of drug-related problems in nursing home patients, and of the positive effects of pharmacist intervention to alleviate these problems, have resulted in a call for expanded pharmacist involvement in drug therapy review in extended care facilities.(17)

These selected reports are cited to demonstrate that direct patient care activities of the pharmacist--activities which are emphasized in contemporary pharmaceutical education--have had and can continue to have a decided impact on national health priorities. We have not attempted to demonstrate how more traditional, yet still important, activities of the pharmacist in drug procurement and distribution (e.g., the hospital formulary system and unit-dose medication systems) can effect cost savings in health care. Cost savings and other benefits of drug product selection by the pharmacist, as well as of unit-dose drug distribution systems, have been well documented elsewhere.

Legislation: The Federal/College of Pharmacy Partnership

The American Association of Colleges of Pharmacy believes that the high costs of clinically oriented academic programs in pharmacy, coupled with evidence of the cost effectiveness of clinically oriented services provided by pharmacy practitioners, call for a continued, broad-range federal partnership in the financing of pharmaceutical education in the public interest. The Association further believes that continued federal support of pharmaceutical education should be directed toward holding costs to students at a reasonable level, and toward programs that most effectively develop pharmacy graduates as contributors to public policy priorities in health care.

Accordingly, the Association urges continuation of institutional funding of colleges of pharmacy to maintain clinical pharmacy efforts developed under the incentive of prior and current health manpower legislation. Our legislative proposal is attached. It sets forth a scheme we call "Program Priority Grants," which would grant institutions monies for having programs in areas that address national priorities. The proposal also includes scholarship and subsidized loan programs. The one entirely new program it proposes is a federally supported Clinical Pharmacy Residency Program. Currently post-graduate residencies are being accredited in hospitals and community facilities in many important areas: General Clinical Pharmacy, Ambulatory Care, Mental Health, Geriatrics, Toxicology, Pharmacokinetics, Pharmacy Administration, Oncology, Pediatrics, and IV Therapy/Nutrition. Unfortunately, a sufficient number of residencies does not exist to accommodate even half of the highly qualified applicants interested in them. We hope this subcommittee will give serious attention to our proposed residency program.

We have read manpower bills submitted by Senators Richard Schweiker and Edward Kennedy (S. 2144 and S. 2375, respectively). We are grateful for Senator Schweiker's support over the years, and we think many portions of S. 2144 are excellent and show a sensitivity to the needs of our schools and the needs of the American people. The grants for clinical training in ambulatory settings are one such example, but we really thought all the special projects grant ideas were excellent. Our only regret is that these grants, which are competitive rather than entitlement, provide the only means of institutional support. We believe this approach is undesirable, not only because it tends to favor "have" schools over "have-nots," but also because much of the appropriations for the program would be eaten up in its administration. An editorial in the journal Science last year indicated that in 1978, 2700 man-years were invested in proposal writing and 575 man-years in proposal reviewing, with three-quarters of the proposals failing to obtain funding.

We also find S. 2144's loan program lacking. Market-rate loans, subsidized down to 7% during school and training, are not of much use to pharmacy students, whose income expectations are modest.

We support much of Senator Kennedy's bill, although some of our deans have expressed concern over the provision that would require schools to have programs in two out of five listed national priority areas before they could qualify for certain funds. We would also hope that in the contingent-service loan program the interest applicable to pharmacy graduates would be 5% rather than 7% because of their relatively low income potential (less than $20,000 per year immediately after graduating; less than $30,000 throughout their careers). And, although the special projects grants applicable to pharmacy are laudable, the funds proposed to be authorized ($9 million for all VOPP special projects) should be increased significantly. While we appreciate that clinical pharmacy residency programs would be eligible for VOPP special projects funds, we would prefer a separately authorized federally supported Clinical Pharmacy Residency Program within the bill.

We would also favor changing the minority-student requirement from 15% to 10% to make a few more of our schools eligible for the additional funding in Sec. 772(i)(2)(A)(ii). We have some schools in the 10-15% range that have made valiant attempts to recruit and retain students from underrepresented minority groups. In many cases the schools have spent large amounts of money in these efforts and feel they have "saturated the market." We do not feel this request is unreasonable in view of the fact that the pharmacy colleges have made such enormous strides in attracting female students (43% of our students are women) and are therefore not eligible for the bill's Projects for Women in Health funds.

Conclusion

The American Association of Colleges of Pharmacy recognizes that federal financing of pharmaceutical education must be based on documented pharmacy practice achievements as they relate to national health priorities, including cost containment. Evaluative research to date indicates that direct patient-care activities of pharmacists -- activities which reflect the direction of contemporary pharmaceutical education -- have had a positive impact on patient-care and health-care costs. The substantially increased costs of clinically oriented academic programs in pharmacy enforce the need for continuing the federal/college of pharmacy partnership in financing of pharmaceutical education. If this partnership dissolves, our schools' clinical programs will be in serious jeopardy.

We are fully aware that the pressure is on this Congress to balance the federal budget next year, and that cuts in health and education programs can be anticipated. Nevertheless, we believe pharmacy colleges have demonstrated that their contribution to the public interest, both in human terms and in terms of cost-containment, merits continued federal support.

Thank you for this opportunity to present our views.

References

1. Nold, E.G. and Pathak, D.A., *Am. J. Hosp. Pharm.*, 34, 823(1977).
2. Fudge, R.P., Vlasses, P.H., *ibid.*, 34, 831(1977)
3. Ivey, M., Riella, M., Mueller, W., and Scribner, B., *ibid*, 32, 1032(1975).
4. Patterson, L. E. and Huether, R.J., *Am. J. Hosp. Pharm.*, 35, 1373(1978).
5. Sczupak, C.A. and Conrad, W.F., ibid., 34, 1238(1977).
6. McKenney, J.M., et al., *Circulation*, 48, 1104(1973).
7. *The Pharmacist as a Primary Provider of Maintenance Care: Final Report* (PB-258 186), National Technical Information Service, Springfield, VA (30 June 1975).
8. Gong, W.C., personal communication (1 May 1978), School of Pharmacy, University of Southern California, 1985 Zonal Ave., Los Angeles CA 90033.
9. Marshall, G., *Hospitals*, 48, 79(1974).
10. Klotz, R. and Steffens, S., *Am. J. Hosp. Pharm.* 33, 349(1976).
11. Jacoby, K.E. personal communication (20 February 1978), School of Pharmacy, University of California, San Francisco, CA 94143.
12. Schwartz, J.I. and Swanson, L.N., *Hosp. Form.*, 11, 34(1976).
13. Ryan, P.B., Johnson, C.A. and Rapp, R.P., *Am. J. Hosp. Pharm.*, 32, 389(1975).
14. Cheung, A. and Kayne, R., *Calif. Pharmacist*, 23, 22(September 1975).
15. Anderson, D.A., et al., unpublished paper.
16. Kidder, S.W.: *NARD J.*, 100, 21(1978)
17. *Long Term Care Facility Improvement Campaign Monograph No. 2. Physicians' Drug Prescribing Patterns in Skilled Nursing Facilities*, U.S. Department of Health, Education, and Welfare, Office of Long Term Care, Washington DC (June 1976).

THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY 1/80

PROPOSAL FOR HEALTH MANPOWER LEGISLATION FOR PHARMACY

The American Association of Colleges of Pharmacy has considered at length various possibilities for a new bill and has concluded that legislation based upon capitation or some other form of institutional support such as Priority Program Grants would be fairest, most effective, and most easily managed. In addition to institutional support, we are suggesting a program of competitive awards to stimulate leadership and excellence; special support for minority students; and a new residency program.

INSTITUTIONAL SUPPORT

BACKGROUND

The current legislation authorizes capitation awards of $695 per pharmacy student. Colleges of pharmacy have received the lowest per capita institutional awards of any of the colleges of the health professions. The reduction in federal support does not reflect trends in educational costs. During FY 1980, the Bureau of Health Manpower estimates that colleges of pharmacy will receive only $223 per student. We believe support should be increased to reflect:

1. The existence of a new and costly required clinical pharmacy component in the program of every college of pharmacy. Note that pharmacy is the only health profession required to undertake such a mandatory program in order to qualify for support. The IOM health professions education costs study confirms the high cost of clinical education. When the IOM study was undertaken, only about 15 percent of the studies of final year pharmacy students was clinical in nature and today that component represents 55 percent of the senior year program.
2. Inflation.

"PRIORITY PROGRAM GRANTS"

We suggest that institutional support be tied to the implementation of federal health priorities in a scheme that could be referred to as "Priority Program Grants"(PPGs). A listing of ten-or-so federal priorities for pharmacy colleges should be developed. It would probably include such items as Clinical Pharmacy; Cost Containment; Geriatrics; Preventive Health; Nutrition; Mental Health; Primary Care; Care for the Poor; Drug Abuse and Misuse; Increasing participation by women, minorities, and the economically disadvantaged in the health professions; correcting geographic imbalances in health care; and Developing interdisciplinary approaches to total health care.

We propose that in order to qualify for the federal support, each pharmacy college be required to include in its curriculum material on a given number of the priorities -- perhaps three or four. Upon making the assurances and supplying a very brief description of qualifying programs*, schools would be entitled to the support; they would not have to compete for it.

INSTITUTIONAL SUPPORT IN COMBINATION WITH PPGs

Another way to implement federal support would be to distribute to the schools a certain amount of money as "institutional support" (calculated to be half of what the law contemplates as the maximum support to be authorized), with schools having the opportunity to receive the other 50 percent of their support in the form of Priority Program Grants if they have qualifying programs, e.g. programs in three out of ten listed priority areas.

Another variation on this theme would be to distribute to a school 50 percent of its institutional support outright, and an additional 10 percent for each program it has in a listed priority area, so that five programs would entitle it to 100 percent of its possible maximum support.

DETERMINATION OF INSTITUTIONAL SUPPORT

The level of institutional support could be determined in various ways. It could be in the form of a lump sum for each institution or, as in the past, based on student population (capitation). If capitation is favored, it should be renamed "Student Population Grants," since the term "capitation" has been associated with incentives for enrollment increases. Since enrollment increases are no longer a federal health priority, it is suggested that if a capitation scheme is used, schools should not be given an incentive for expansion, and should not be penalized for failing to reach a certain minimum level.

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* To keep government and school paperwork to a minimum.

COSTS

In 1972 the Institute of Medicine, in its study Costs of Education in the Health Professions, recommended that, since health professions schools are a national resource, the federal government should subsidize them at a level of 25 to 40 percent of educational costs. It is suggested that this recommendation be used to determine the amount of institutional support -- be it in the form of grants, lump sum, or capitation.

Educational cost data in health professions education are not abundantly available; become complicated by the education/service mix of the programs; suffer from inter-institutional comparability weaknesses; and are difficult and expensive to obtain. The problems are compounded for pharmacy because of the undergraduate professional-post graduate professional mix and the rapid development of the costly clinical component of the curriculum. The Institute of Medicine study was done during a period in which less than 20 percent of the final year of pharmacy study was devoted to clinical instruction. Today over 50 percent of the final year is clinically oriented. Nevertheless, the IOM study does provide a benchmark in the determination of the costs of pharmacy education. The educational cost figures determined in 1972, when adjusted by the Consumer Price Index, would yield a 1979-1980 educational cost per student of $6,088.

In order to estimate pharmacy education costs and to project them into the future, the 1979-1980 estimate was inflated by eight percent, the annual inflation rate over recent years. The determination of total costs was calculated by applying the inflated cost per student figure to a declining student population. It is recognized, of course, that educational costs are both fixed and variable, meaning the colleges cannot directly reduce costs in line with enrollment. Following the IOM recommendation, a federal share of costs was determined at the ends of the 25 percent to 40 percent of total costs range. If this direction were followed, the total costs over a five-year period of institutional support could be maintained at a relatively even level while costs per student would undergo a relatively larger increment. Such an approach would allow colleges to provide program stability and maintain, and even enhance, program quality. The computations described are found in the table that follows:

Year	Enrollments	Cost/student	Total Costs	Federal Share at 25% of Total Costs	25%/student	Federal Share at 40% of Total Costs	40%/student
1979-80	29,000	$6,088	$176,552,000	$44,138,000	$1,522	$70,620,800	$2,435
1980-81	27,500	6,475	178,062,500	44,515,625	1,619	71,225,000	2,590
1981-82	25,000	6,993	174,825,000	43,706,250	1,748	69,930,000	2,797
1982-83	22,500	7,552	169,920,000	42,480,000	1,888	67,968,000	3,021
1983-84	20,000	8,156	163,120,000	40,780,000	2,039	65,248,000	3,262
1984-85	20,000	8,808	176,160,000	44,040,000	2,202	70,464,000	3,523

UNDERREPRESENTED AND DISADVANTAGED STUDENTS

BACKGROUND

Support is needed to encourage the recruitment and enrollment of students from underrepresented minorities and disadvantaged backgrounds. If a capitation (or SPG) system of support is used, we believe colleges should be allowed to include these students in the enrollment count even when they require more than the usual time to complete an academic program. Presently, repeating students cannot be included in capitation counts. Such an option should be managed within reasonable boundaries but the regulations should not penalize colleges for extending the extra time and effort that may be required to compensate for previous educational disadvantages.

BONUS SYSTEM UNDER SPG PROGRAM

We would recommend that consideration be given to a capitation bonus of 50 percent of authorization for each student enrolled from an underrepresented minority. If a capitation (or SPG) figure of $1,522 (the modest 25 percent IOM figure) is used, the amount per minority student would be 150 percent of $1,522, or $2,283. In addition to creating the incentive to attract these students into pharmacy, the bonus should help to solve the financial problems that beset our four predominantly minority pharmacy colleges.

BONUS SYSTEM UNDER LUMP SUM SUPPORT PROGRAM

If a lump sum figure for support is used, it still would be appropriate to use a capitation (or SPG) system for determining the school's level of support for assisting disadvantaged or underrepresented minority students.

COSTS

The disadvantaged student bonus, at 50 percent of the level of the student population grants (taken at the modest 25 percent IOM figure) would cost an estimated $2.74 million in year one with an enrollment of 3,600 minority students. With an estimated 200 per year increase in minority enrollments, the costs would reach $4.85 million in year five. If this enrollment target is reached, the student populations of schools of pharmacy would be composed of 22 percent minority students.

SPECIAL PROJECTS GRANTS

Special projects grants should be available on a competitive basis to pharmacy colleges in the following areas, reflecting national health priorities:

Faculty development; retraining of basic sciences faculty for clinical teaching (especially important to small schools that cannot afford to bring in new, highly trained faculty from the outside).

Interdisciplinary training.

Curriculum development - general.

Curriculum development in nutrition, mental health pharmacy, cost containment, geriatrics, home health care, preventive health, etc.

Minority recruitment, retention and placement.

Pharmacokinetics/Clinical Pharmacokinetics training (our schools are experiencing a severe shortage).

Special track in long-term care.

Innovative training in non-prescription drug areas, health education, surgical appliances, maternal and child care, etc.

We feel, however, that special projects grants should not be relied upon as a major source of institutional funding. While they can be useful in addressing national priorities, they tend to be inflationary and require burdensome bureaucracies at both the proposal-writing end and the proposal-reading end. It has been estimated that in 1978, 2700 man-years were invested in proposal writing and 3300 man-years in proposal reviewing, with about three-quarters of the proposals failing to obtain funding.

FINANCIAL DISTRESS GRANTS

We recommend that the current program be maintained with continuation of the recently introduced exemption from the phase-out requirements.

CONSTRUCTION GRANTS

Construction funds should be available for (1) renovations for clinical training and (2) off-campus facilities in underserved areas. The changes in pharmacy education require more of the program to take place in a patient care setting. While facilities exist to handle the numbers of students needed, these faciltities are often inappropriate. For obvious reasons construction funds should no longer be tied to enrollment increases.

STUDENT ASSISTANCE

BACKGROUND

Since a pharmacist's salary throughout his or her entire career remains only in the $20,000 per year range, it is inappropriate to expect him or her to pay high tuitions or to incur heavy debts.

LOANS

Health professions student loans should be expanded and should be offered as a seven percent interest program with interest subsidy available to needy students; program would be channeled through private lending institutions which would make money available at the current prime rate. The federal government would subsidize the interest, insure the loans, and pay the banks' administrative costs.

SCHOLARSHIPS

Health professions schools scholarship program should be reinstated for lower-middle-income students, and each profession should receive an allotted number.

AID FOR ESPECIALLY NEEDY STUDENTS

Aid for especially needy students should continue to exist separately from other programs and from the National Health Scholarship Corps. Disadvantaged students are reluctant to commit themselves to a significant service contract when in doubt about completing the academic program.

RESIDENCIES

Federal support should exist for clinical training residencies. Students eligible should be post-BS students in a degree or non-degree program. Students in their final year of an MS or a Pharm.D. program should be eligible if their programs have a certain minimum clinical component. The federal support should cover only clinical, non-academic training. Clinical training could be in the community as well as in hospitals.

The suggested level of support is an annual stipend of $14,000 (plus an inflation factor) for each covered student plus 20 percent for the student's institution for a maximum of two years.

During the first year of support, it is suggested that 100 residencies be created; during the second year 150 residencies (plus 100 carried over from the preceding year); during the third year, 200 residencies (plus 150 carried over); during the fourth year, 250 residencies (plus 200); during the fifth year, 300 residencies (plus 250).

Thus, with this federal incentive, the number of clinical training residencies will have doubled (from the present 300) in five years. The maximum costs with stipend support at $14,000 per annum would be $1.4 million in year one, $3.5 million in year two, $4.9 million in year three, $6.3 million in year four and

$7.7 million in year five. The costs are an outside figure since most residencies are only of one year duration. The total support would be approximately 75% of the maximum figures.

It shoud be noted that the American Society of Hospital Pharmacists, the accrediting body for basic institutional pharmacy residency programs, reports that approximately 2.5 highly qualified pharmacy graduates apply for each residency program. They report that career opportunities for graduates of residencies are ample and expanding. They note a demand for more highly trained pharmacists in administrative, technical and clinical specialties. Moreover, colleges of pharmacy are actively seeking additional practitioner faculty members and are attempting to develop even more sophisticated clinical scientists-practitioner faculty.

The American Association of Colleges of Pharmacy appreciates this opportunity to provide you with our recommendations regarding new health manpower legislation. We hope that you find our proposal to be of interest. We look forward to working with you in developing a new bi'l that will be responsive to the needs of students, colleges and, most of all, the public.

Senator **Metzenbaum**. Thank you very much, Dr. Rodowskas. I do not have any questions.

Senator Schweiker has a few and he will conclude the hearing, and I want to apologize to Dr. McMahon, the president of the American Hospital Association, for my inability to remain for his testimony.

Senator Schweiker.

Senator **Schweiker** [presiding]. Thank you, Mr. Chairman.

Dr. Bates, I understand that podiatry schools, to the extent the resources permit, place great emphasis on clinical outreach programs. What we call remote site training.

To what extent have podiatry schools been able to accomplish this goal and has it resulted in wider dispersion of podiatrists?

Dr. **Bates**. Senator, we are just beginning to get into that area. Now, personally, in Pennsylvania, we are now talking with sites in Georgia, Western Pennsylvania where we hope to send a student, a series of students, give to 10, and some cases 20, and we are also talking about Tennessee, incidently, for a full year, and we found that where you get a student into an area, that many times they will stay in that area. We do not have any track record to show it, but we do think it has an awful lot of merit, that proposal.

Senator **Schweiker**. Dr. Peters, your statement expresses support for new authorities in my bill, S. 2144, for remote training, clinical development and other areas, including continuing education projects and research and demonstration in reducing educational costs.

Could you mention a few of the programs that schools of optometry, such as your own, would be interested in carrying out under these authorities?

Dr. **Peters**. There are major opportunities and the optometry schools have been actively developing these for the last 5 to 10 years in remote clinical sites and special education programs serving unique populations.

My own institution has a program with a regional center for the blind that is at some distance from the university but to which we send students, faculty and staff on a regular basis. There are many other such opportunities in the regions of each of the schools since the schools are so widely geographically distributed.

Senator **Schweiker**. Thank you.

Dr. Melby, my bill would permit, if needed, new veterinary schools. I wonder if you could explain to me why your association also finds a continuing need for more veterinarians?

Dr. **Melby**. The demand for entrance in veterinary schools continues almost unabated. There has been an increasing role, expanding role played in veterinary medicine which has been unparalleled in the last decade or two.

Senator **Schweiker**. Well, we thank the panel very much for participating today, and we appreciate your concise statements. Of course, the time forces us to make them so condensed but we will put the whole statement in the record. Thank you.

We will call as our last witness Alexander McMahon, president of the American Hospital Association.

We welcome you here this morning. Sorry you are the windup witness. But to a baseball team, that is the best part of the batting order.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY MICHAEL M. HASH, ACTING DIRECTOR, WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION

Mr. **McMahon**. In light of the support that you have given us in many other matters, it is a pleasure to appear before you and to have you in the chair, sir.

I am Alexander McMahon, president of the American Hospital Association. Accompanying me is Michael M. Hash, the acting director of our Washington office. We are representing the American Hospital Association and its 6,100 hospitals and other health care institutions and 30,000 individual members.

As perhaps you have noted, Mr. Chairman, our testimony deals in detail with nursing education in particular and medical and allied health education in general.

With respect to the nursing education issues, we have described the nursing shortage in some detail. We may shed some light on the dialog that you had earlier with Dr. Davis on the need for continuing Federal support for nursing education programs. We commented on the bills before the committee in the written statement.

I would note specifically the need for hospital schools of nursing with their unique contribution to the education of nurses for the hospital setting.

With respect to medical and allied health education, we commented on many of the provisions in the bills before the committee, and again hospitals have a great interest both in terms of the costs that they already bear for these programs and for the service implications. Again we have offered a number of important suggestions.

With respect to our own testimony, Mr. Chairman, we have paid particular attention to the funds for construction of ambulatory facilities, for programs aimed at the underserved areas and specifically for the development of manpower data, very important for policymaking in the future.

Finally, Mr. Chairman, I close with a comment with respect to the problems of hospital costs. This is a key public policy issue, as we have pointed out in other testimony before this committee, and I remember particularly, Mr. Chairman, your own support when we appeared earlier last year with respect to bills dealing with hospital cost containment. The educational programs before this committee have a profound impact on hospital costs.

If there is a reduction of Federal support which, in turn, reduces enrollment in many of these programs, there will be greater shortages, higher salaries and higher costs. On the other hand, Mr. Chairman, with a reduction of Federal funds, opportunities for low income and minority people hospital dollars, have to be substituted, once again there will be an impact on hospital costs. If the committee does decide to reduce some of the Federal support, I hope the report will point out that there is quite likely to be an impact on hospital costs for the future.

Mr. Chairman, that concludes my brief oral statement. I understand the testimony in full will be filed for the record and we will look forward to cooperating with the committee, both majority and minority, and with their staff in the weeks ahead as you continue your study of these measures.

[The prepared statement of Mr. McMahon follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH OF THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE ON PENDING HEALTH MANPOWER PROPOSALS

March 10, 1980

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Michael M. Hash, acting director of the AHA's Washington office. The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on health manpower legislation pending before this Subcommittee.

INTRODUCTION

Hospitals are sincerely committed to the delivery of high quality, cost-effective health care services to the patients they serve. In order to accomplish this mission, there must be an adequate supply of highly qualified health professionals to meet the staffing requirements of our nation's health care institutions. Moreover, many hospitals are directly involved in educational programs for health professionals by sponsoring clinical programs for graduate medical education, operating hospital-based nursing education programs, and conducting a variety of allied health education programs. At the present time, more than 48,000 nursing students are enrolled in hospital schools of nursing, and all nursing students receive at least part of their clinical training in hospitals. In addition, some 50,000 interns and residents, and a substantial number of allied health professionals, receive significant portions of their educational experiences in hospitals.

The hospital system is, of course, a principal employer of such health professionals and, as such, is vitally concerned with federal policies affecting health manpower and, more particularly, federal financial support to manpower education.

The delivery of health care services in the hospital setting has changed dramatically in recent years. Advancements in medical practices and technology, utilization review, and the emergence of new health practitioners and institutions have significantly affected hospital operations. Patients are generally more acutely ill and their inpatient stays are shorter, and the intensity and sophistication of services have placed new demands on health professionals. Now more than ever, the educational process must be capable of meeting these challenges by having the resources to strengthen faculties, expand opportunities for clinical training, and recruit an adequate supply of qualified students.

The AHA has strongly supported existing authorities in Titles VII and VIII of the Public Health Service Act that are the foci of these hearings. We recognize the significant contribution by the federal government to the development and enhancement of programs for health professions education, and we are here today to urge continuation of these commitments. We are convinced that the cessation of federal support in this area or a precipitous decline in such aid would have an adverse impact on the ability of hospitals to meet the health care needs of their communities, and would exacerbate the problems of manpower shortages and maldistributions.

While we are aware of aggregate increases in the total supply of health professionals, we would like to point out that in certain fields, such as nursing and the allied health professions, hospitals are experiencing severe and chronic shortages. We take strong exception to the position of the Administration that federal financial assistance to medical and other health professions schools should be dramatically reduced or terminated. The loss of these federal funds would place many educational institutions in financial jeopardy, price such education out of the reach of most Americans, and adversely affect the quality and accessibility of health care services.

In preparation for these hearings, we have reviewed S.2375, introduced by Senator Kennedy; S.2144, introduced by Senator Schweiker; and S.2378, introduced by Senator Javits. In addition, we have examined the recommendations pertaining to funding for health professions education contained in the President's proposed Fiscal Year 1981 budget. Our specific comments on this legislation will deal first with proposals to revise Title VIII, authorities relating to nursing education, and second with the proposed revisions to those sections of Title VII, relating to medical and allied health education.

TITLE VIII

Nursing Education

The Nursing Shortage

Federal support to nursing education is a national issue of great concern to the AHA. Among the 6,100 hospitals which comprise our membership, 344 conduct educational programs to prepare students for professional nursing; of these, 249 form an AHA membership group, the Assembly of Hospital Schools of Nursing. Hospitals also contribute significantly to the education of nurses in both basic and advanced educational programs by serving as clinical facilities for the practical component of such programs.

Moreover, hospitals are the major employers of nurses. A 1977 HEW-funded study revealed that more than 61 percent of the nation's practicing registered nurses (RNs) were employed in the hospital setting. It is clear that, despite alternative delivery systems and other employment opportunities, the majority of today's nurses work in hospitals.

Contrary to Administration statements that most programs of nursing education no longer require federal support because there are sufficient numbers of nurses, hospitals across the country are reporting critical shortages of nursing personnel. AHA member hospitals indicate that they have between 90,000 and 100,000 vacancies, and a recent article in Nursing '79 stated that 80 percent of the nation's hospitals currently have nursing vacancies.

Data from state hospital associations confirm this shortage. According to a recent survey of the associations, virtually every state is affected. For example, the Maryland Hospital Association reported that the state's community hospitals are suffering an average 14 percent shortage, which "cuts across all kinds of hospitals in all parts of the state." In the Baltimore area, which includes the city and five surrounding counties, the shortage was pegged at 14.8 percent. California indicated a 17 percent vacancy rate for full-time budgeted positions in hospitals, while Texas reported that more than 12 percent of budgeted positions were unfilled. Virginia and Tennessee responded that hospitals in those states had been forced to close beds--127 in the City of Memphis Hospital System alone--in recent months due to the impossibility of obtaining sufficient nurses to provide adequate care. Georgia reported that one in eight full-time budgeted positions in the state's hospitals was vacant, and yet there were over 500 vacancies in schools of nursing this academic year. In Indiana, 84 hospitals had 1,000 vacant budgeted positions for RNs. Pennsylvania indicated 1,550 budgeted vacancies in hospitals throughout the state.

According to the Department of Labor's Bureau of Labor Statistics, of job openings in the health care field in the 1980's, up to 50 percent will be for nurses--approximately 83,000 annual openings for RNs. The American Nurses' Association cites higher figures, predicting that, by 1982, there will be a nationwide shortage of 100,000 nurses.

In spite of such shortages, the number of graduating nurses declined 2 percent in 1979--the first time in 10 years that fewer nurses were graduated than the year before--according to data from the National League for Nursing. The league also reports that applications to RN programs dropped 16 percent between 1977 and 1978. With the rate of unemployment for nurses--also 2 percent--remaining far below the norms for other categories of comparable professionals, the league predicts that the current nursing shortage will become even worse in the near future.

A recent report of the AHA's Advisory Panel on the Nurse Shortage explains that the problem exists not only in regions, states, and counties, but also within single facilities. Many hospitals reporting unfilled budgeted positions indicate greater difficulty in recruiting for evening and night shifts and for particular units--intensive care, coronary care, psychiatric, and geriatric.

Compounding the problem is the trend toward shorter lengths of stay by more acutely ill patients requiring more technologically complex nursing care. The creation of intensive care units and specialized services within hospitals has resulted in increased demand for RNs, as have changes in the utilization patterns of hospitals, with shorter stays reflecting a greater focus on planning admissions and discharges and greater use of outpatient facilities. American Nurses' Association data reflect this demand, showing that hospitals have hired increasing numbers of RNs in the past few years to handle such units and services.

Special care units have developed with increasing momentum during the past three decades in response to new medical knowledge and technological advances. Specially trained nurses provide the essential minute-to-minute surveillance which permits them to function in emergency situations in life-saving capacities before the arrival of physicians. For instance, data from one cardiac care unit indicated that prompt intervention of a life-saving nature by nurses occurred in the cases of 32 percent of patients. For a further example: the number of nursing hours per patient day in a New York hospital's burn care center was calculated at 14, compared with the average figure of 4.5 nursing hours for a patient in a general surgical unit; a review of 1,000 admissions to the same unit during a four-year period not only showed a reduction in deaths due to burns but also a decrease in hospital stays of approximately one-third during the acute phase of burn treatment.

AHA Actions

Nursing is a priority issue on the Association's 1980 agenda. One way in which we are addressing these concerns is by sponsoring a national commission on hospital nursing services. The commission will identify issues and formulate approaches for resolving problems now being experienced by hospitals in the provision of nursing services. In doing so, the commission will focus on hospital nursing manpower requirements created by the hospital's reason for being—patient care—and its role as the primary community resource for health care. This goal will require a comprehensive analysis of the entire continuum, starting with nursing manpower planning and moving to student recruitment and selection, career development and mobility, educational preparation for required competencies, job placement and utilization, productivity and motivation, professional and economic incentives, and retention, and ending with continuing education to maintain competencies and provide ongoing professional growth.

In addition, the AHA has planned a variety of programs designed to attract nurses into hospitals, to persuade inactive nurses to return to the hospital work force, and to accentuate those in-hospital management practices that encourage the retention of nurses.

Guidelines for Federal Support

In view of the current nursing shortage crisis, the AHA believes that federal support for all types of nursing education should continue. In our opinion, the general principles governing such support should include (1) equitable distribution among the three types of basic nursing education curriculum and between basic and advanced nursing programs, (2) emphasis in program support on those nursing curricula that provide for articulation among nursing programs, thereby offering career ladders to those in diploma and associate degree programs, and (3) encouragement of entry into the nursing profession at a time when other fields are presenting competitive challenges to more traditional women's occupations, such as nursing.

Capitation Grants

The AHA supports the continuation of capitation grants to all three types of basic nursing curricula: diploma, associate degree, and baccalaureate degree. The elimination of such support, as proposed by both the Administration and Senator Schweiker in S.2144, would cause many of the schools to undergo serious financial difficulties. In addition, the President is expected to request a rescission of all the capitation funds currently appropriated for this fiscal year. Nursing schools are dependent on capitation funds for general support, which is vital if they are to help meet the increasing demand for more hospital-based nurses and more nurses to fill positions in alternative settings. They also are dependent on such funds for enlargement of faculties, of which there is currently a serious shortage. Without such funds, the shortage would be aggravated, resulting in cutbacks in educational programs.

Extensive nursing manpower studies funded by HEW to project future needs under a variety of system changes, ranging from reorganization of the health care delivery system under proposals for national health insurance to reformulation of nursing roles, conclude that there will be an expansion of demand for professional nurses. Most projected scenarios call for more nurses than can be educated under current conditions, according to these studies.

The AHA is generally supportive of the alternative proposal in S.2375 that would authorize basic institutional support and incentive grants, as means of maintaining the fiscal viability of many schools. In addition, the AHA endorses the provision that encourages articulation for diploma and associate degree programs. This provision would give many nurses who might otherwise not meet admissions criteria the opportunity to enter graduate education programs in nursing, thereby enhancing their career potential.

However, the AHA has the following recommendations for S.2375: First, for the purpose of calculating the size of grants for diploma and associate degree programs, the definition of "full-time student" should be expanded to include full-time equivalencies, as is presently the case for baccalaureate degree programs. This change would encourage flexible programming, designed to attract mature persons entering the field for the first time, as well as licensed practical nurses desiring to become RNs. Second, while the AHA generally endorses the criteria that would be used to increase or decrease the base-level of support, we object to the provision that 25 percent of a school's graduates be employed in states with a lower ratio of employed nurses to the population than in three-quarters of all states. Implementation of such a provision would be administratively complicated, as well as unrealistic, because it is based on the assumption that a school can control where its students choose to be employed.

Special Project Grants

We are pleased to note that S.2375, S.2144, and the Administration's draft proposal all extend authority for special project grants. We support the continuation of such grants to increase the supply or improve the distribution by geographic area of adequately trained personnel; to provide more opportunities for disadvantaged or minority nurses; and to improve curricula, including those for pediatric and geriatric nursing. We suggest, however, that pediatric curricula stress well-child care as well as services to sick children, recognizing the benefits of preventive services for children.

We do not believe that it is necessary to provide special consideration for the development of programs of continuing education for practicing nurses, because many such programs already are offered by private organizations, or as part of inservice training within institutions. Although AHA supports the principle of continuing education for all health care professionals, we do not consider it a national priority for federal funding. Furthermore, we are concerned about the use of the term, "and other para-professional nursing personnel," in S.2375, because the bill already identifies professional, practical, and nursing assistants. It is our perception that an increase in the categories of those who provide care leads to a fragmentation in care provided. Therefore, we ask the Subcommittee to consider carefully the implications of developing non-accredited courses for new types of nursing personnel.

Clinical Education and Practice

The AHA supports the provision in S.2375 which calls for increased federal assistance for clinical education programs to both basic and advanced nurse training programs. According to hospital administrators, many basic education programs do not afford sufficient emphasis on clinical training, which must then be provided on the job. Exposure to such training may also motivate students to choose the hospital setting as a work environment upon completion of their basic programs. Moreover, because of the increase in technology and the development of special care units, clinical training is essential at the advanced level to prepare nurses to meet the challenges of specialized nursing in the hospital setting.

We recommend, however, that, in this section of the bill, the term, "primary nursing care," be replaced with the clearer and more generally accepted terminology, "clinical nursing."

Student Assistance

The AHA supports the continuation of the student loan program. We prefer the current authority, which gives the student the option of serving in a medically underserved area in lieu of repaying a loan. It is our understanding that S.2735 would mandate a service pool for nurses similar to that established for physicians in Title VII, and the amount of loans which would be made available to nursing students would increase significantly, from $15 million to $75 million annually.

However, the AHA does have some reservations about provisions in the related Section 824, which would establish criteria for the designation of nurse shortage areas, criteria which might be difficult to administer. Although current law authorizes the designation of health facilities as medically underserved, HEW has been reluctant to implement this provision. We are concerned that this problem could continue under the procedure prescribed by section 824. We urge that the Committee's report on this legislation include specific direction for HEW to give appropriate attention to the designation of hospitals as nursing shortage areas. We also recommend that the process of designating nurse shortage areas be based on the findings of the Institute of Medicine study mandated by P.L.96-76.

In addition, we encourage the Subcommittee to continue the scholarship program for exceptionally needy students and are pleased to note that authority for the program is retained in S.2375. However, both S.2144 and the draft Administration bill would repeal this section.

Advanced Nurse Training

The AHA continues to support advanced nurse training programs which provide funding for three major categories: preparation of nursing faculty, the quality of which has a direct effect on the quality of care given by students to patients; managerial education for supervisory and administrative nurses, most of whom presently rely on on-the-job training; and advanced training in specialty areas, such as gerontology and maternal and child health care.

We particularly endorse innovative work/study programs, and wish to call to your attention a joint program developed recently by the AHA and the University of Illinois School of Nursing. This program enables practicing administrators to combine their continuing work experiences with alternating residential sessions, featuring self-learning modules supplemented by a local preceptor's instruction. Such programs, replicated nationwide, would help meet the urgent need for more highly educated management nurses in hospitals. Such courses should be credit-carrying to enable students to attain degree status by consolidating course work.

Nurse Practitioners

We support continuation of nurse practitioner programs, but oppose the Administration's proposal to concentrate resources in this one program, while virtually eliminating all other nursing support. In our opinion, with limited federal dollars available, efforts should be made to encourage balanced expansion of the total profession rather than excessive development of one discipline or specialty.

National Advisory Council

The Association opposes the dissolution of the National Advisory Council on Nurse Training, as recommended by the Administration and S.2144. This council should be continued because the multiplicity of interests involved in nursing is too great to allow adequate representation on the proposed combined council for all health professions. Moreover, the ANA recommends that the name of the council be changed to the National Advisory Council on Nursing Education.

TITLE VII

Institutional and Student Support

Capitation Program

Existing law authorizes capitation grants to health professions schools to support their educational programs. These grants have provided a stable source of financial support for such schools and have served as a much-needed complement to income from tuition, voluntary contributions, and state governments.

Schools for the health professions depend upon the capitation program as a means of keeping tuition costs at affordable levels and of ensuring that students can continue to be exposed to the most up-to-date scientific and technological advancements in today's fast-changing and highly complex health care field.

Our Association is concerned that precipitous withdrawal of capitation monies from health professions schools would place many of these institutions in a state of financial crisis. Based upon the present capitation formulas, many schools have entered into binding, long-term commitments, and some could be placed in serious financial jeopardy if this source of funding were eliminated.

We are, however, cognizant of the need to revise the existing capitation program. Some of the present requirements, such as across-the-board enrollment increases, are inappropriate at a time when we are rapidly approaching a balance of supply and demand in some health professions. For example, recent figures show that enrollment in the nation's medical schools has reached a record high of 63,800 students, and by 1990 we may well have an oversupply of physicians; in contrast, however, we still are experiencing severe shortages of nurses and some allied health professionals, and certain medical Specialists.

We are particularly distressed to note that the Administration's FY 1981 budget for health manpower includes no funds for capitation grants to schools of medicine, osteopathy, and dentistry, or to schools of veterinary medicine, optometry, and podiatry. Moreover, the President is expected to propose rescissions of approximately $37 million in Title VII funds currently appropriated for FY 1980. The Administration has stated that such schools have been anticipating the loss of such funds and that they therefore should be able to make up for this loss of support through other revenue sources. This position is unrealistic, in our view, and could lead to significant cutbacks in opportunities for enrollment in these educational institutions.

In reviewing the legislation pending before this Subcommittee, we believe that the approach to basic institutional support contained in S.2375 would be a workable alternative to the present grant program. A predictable base-level of support, accompanied by opportunities to increase grants through the initiation of special projects in the national interest, would be a proper approach to achieving policy goals through incentives.

However, we have a reservation about the proposal contained in S.2375: some of the objectives that schools would be encouraged to achieve in order to receive capitation grants would not be within their control. For example, they could be penalized because of decisions made by their students regarding practice location or specialty.

S.2144 would establish a process whereby eligible health professions schools would apply for grants to help meet the costs of certain special projects in lieu of any basic level of institutional support. While the projects identified by the bill represent activities that are supportive of national goals for health professions education programs, we do not believe this approach would provide the financial support that would be necessary if all capitation funds were terminated.

Student Assistance

Student assistance is fundamental to development of the health professions. Recent increases in tuition, particularly in private schools, have made health careers unaffordable for many low- and middle-income individuals. Medical students can incur debts of up to $50,000 by the time they graduate, making them unable to establish credit for any other purpose. The reduction in federal funds that would result from enactment of any of the proposed programs of institutional support could only aggravate this situation by causing substantial tuition increases.

S.2375 would retain the National Health Service Corps scholarship program, the Health Education Assistance Loan program, scholarships for students with exceptional financial needs, and traineeships for students in public health and health administration. The health professions student loan program would be consolidated into a need-based, campus-originated loan program. Each loan would commit the borrower to a potential service obligation; a loan recipient also could volunteer for federal service and have the loan forgiven.

We think the service-contingent loan program is a realistic and innovative method for making low-interest loans available for students in financial need and to further national policy aimed at more appropriate distribution of health manpower. Students eligible for federal service would be potentially on call for only a limited period of time, thus enabling them to make career plans. Further, the total amount of loans available to nursing students would be increased from $15 million to $75 million annually, as we noted earlier.

Construction Authorities

Title VII authorizes grants, loan guarantees, and interest subsidies for the construction of teaching facilities for health professions, and ambulatory primary care teaching facilities for the training of medical, osteopathic, and dental students. The Administration proposes to eliminate these funds entirely.

The AHA supports the approach taken in S.2144: to authorize funds for construction of new schools for the education of health professionals who currently are in short supply and for renovation or modernization of teaching facilities that are outmoded.

We especially welcome the provisions in S.2375 and in S.2144 that would provide funds for ambulatory care teaching facilities. The inadequate facilities available at some institutions have severely restricted the teaching of primary care practice. Outpatient visits, the largest proportion of which are made in teaching hospitals, increased nationally from 1970 to 1978 by 55 percent--from 137 million to 212 million visits. Not only has this placed an enormous strain on facilities, but it also has been a major factor in changing hospital ambulatory programs as they increasingly parallel patterns of care established in private and group practices. The change in practice patterns has frequently required modification of a hospital's structure and, in many instances, has required the creation of satellite ambulatory facilities. These trends were clearly recognized in the 10 principles enunciated in the health planning amendments of 1979, including an increase in ambulatory services and in the affiliation of institutional providers with medical group practices. Clearly, as the AHA pointed out in testimony on that legislation, hospitals must provide space and appropriate facilities in the implementation of such principles.

Project Grants and Contracts

Title VII contains a variety of categorical authorities which relate to area health education centers (AHECs), primary care education, access of disadvantaged persons to health careers, allied health education, public health education, and health administration. We would like to comment on some of the provisions contained in the bills before the Subcommittee that would extend these authorities.

Area Health Education Centers

Section 781 of the existing law authorizes the development of AHECs for the conduct of graduate, postgraduate, and continuing education programs in medically underserved areas. In our opinion, this very worthwhile program has been used effectively to meet the health care needs of rural areas, while serving as a mechanism to encourage health care practitioners to locate and remain in underserved communities.

Both S.2375 and S.2144 would continue the AHEC program. S.2375 would enhance the present authority by adding a provision to allow for the establishment of AHECs in urban underserved areas, a modification which the AHA supports.

Initiatives for Serving Underserved Populations

Under the present law, there is no authority to provide funds for the conduct of educational programs in underserved areas except through an AHEC. Both S.2375 and S.2144 would create new authorities that would expand opportunities to undertake initiatives in medically underserved areas.

S.2375 would add a new section 791 that would authorize grants to health professions schools and other appropriate entities to encourage enrollment of students from medically underserved areas, as well as to develop programs for the provision of care in such areas. S.2144 would authorize grants to health professions schools for projects to provide students with clinical training in medically underserved areas and to provide support services to physicians and dentists practicing in these areas.

We believe that both of these proposals are worthwhile and would recommend that they be included in any legislation reported by the Subcommittee.

Allied Health Personnel

Under existing law, grants are available to health professions schools, states or political subdivisions of states, and other public or nonprofit entities to assist in planning and operating allied health education programs. Special emphasis is placed on projects that coordinate education and training programs among the health professions, as well as on programs that establish new roles and functions and meaningful career ladders for allied health personnel.

The Administration's FY 1981 budget, citing the pending oversupply of health personnel, proposes drastic cuts in funds for allied health education. It is our view that this drastic decrease in funding is unwarranted. We do not concur with the Administration's claim that there now is a pending oversupply of allied health professionals--a claim that is inconsistent with a preliminary HEW report on allied health personnel which reflects widespread shortages and cites programs in some states that are having problems in recruiting students. Such recruitment problems are bound to increase, particularly if predictions materialize that the 18 to 24 age group in our population will decline in number substantially in the coming years and there will be a smaller pool of potential students from which to draw. Rather than an oversupply of allied health professionals--as a result of the emphasis in the existing statute on the development of new roles and types of health practitioners--there has been a proliferation of such personnel who are highly-specialized. It is this over-specialization that we believe is unwarranted. A striking example is in the category of cardiology technologists/technicians in which nine subcategories are identified in the 1979 edition of The Health Careers Guidebook jointly prepared by the Departments of Labor and HEW. These subcategories did not exist a decade ago.

Finally, we consider it irresponsible of the Administration to suggest that state and local governments will be able to compensate for the proposed drastic cuts in funding for health professions education at the federal level. Given the present state of the economy and the financial difficulties of many of our major urban centers—where a majority of programs for the training of allied health professionals exist—severe curtailment of federal funds would be certain to undermine valuable educational resources.

We are pleased that both S.2375 and S.2144 would eliminate in section 796 of the existing law the language related to creating new roles and functions for allied health personnel, and would instead place emphasis on improving clinical competency in such fields as long-term care, hospice service, and disease prevention and health promotion.

We are concerned, however, that S.2144 would limit the program of grants to educational institutions for training allied health personnel, thereby excluding hospitals and other possible clinical sites. Present law authorizes a program of project grants and contracts that includes hospitals affiliated with educational entities among those eligible for participation, and we would recommend that the legislation reported by this Subcommittee include a similar provision. At the present time, approximately 1,100 hospitals provide clinical facilities for more than 7,000 allied health programs in educational institutions, and they cannot completely meet the costs of training allied health professionals through patient care revenues. In fact, some third-party payers have placed limitations on their hospital payments for education. Hence, it is important that hospitals and other clinical sites be eligible for grants for costs related to these special projects.

S.2375 and S.2144 also would provide funds for advanced training of allied health educators and administrators. Such assistance is greatly needed to enhance both the quality of allied health education and the effectiveness of health delivery systems employing allied health personnel. Training of needed teachers and administrators in the allied health professions seems to us to be a very appropriate use of federal funds.

We would like to note our support for a provision in S.2378 which would extend and expand support programs to institutions and students of health administration. Under this new program, grants providing fellowships to students for up to three years would be authorized. In addition, the bill would support management training programs for physicians, nurses, and administrators in health care facilities and authorize research and demonstration projects in health care management. We believe these initiatives would contribute significantly to the field of health services administration, and we are anxious to participate in the study of management in the health care delivery system which is included in this title.

Family Practice/Primary Care Authorities

A major goal of the Health Professions Educational Assistance Act of 1976 was to increase the numbers of primary care physicians and to encourage such practitioners to practice in medically underserved areas of this country. Toward that goal, the law authorizes several programs for grants to medical and osteopathic schools, as well as to hospitals, for the construction and operation of facilities for departments of family medicine; for the operation of training programs in that specialty; and for scholarships, fellowships, and stipends to interns, residents, and other medical personnel who participate in hospital family medicine. In the past, these programs have been well-funded; for FY 1981, an increase of $18 million has been requested by the Administration.

S.2375 would retain the existing authorities for grants to establish and maintain residency programs in family medicine, general internal medicine, and general pediatrics, and would amend the statutory language to include hospitals in addition to medical and osteopathic schools. In view of the fact that many hospitals already are providing residency programs in these disciplines, we support this change and recommend that sections 735 and 737 of S.2144 be similarly amended.

Nonetheless, while we believe that the number of primary care residency positions should be increased, we do not support accomplishing this goal at the expense of other postgraduate positions. It is important that hospitals be able to determine the appropriate number of positions for any approved residency program, taking into account the resources of each institution and the characteristics of the patient population served. To do otherwise could require some institutions to experience serious physician shortages that would have an adverse impact on the delivery of needed care and significantly increase the cost of that care by requiring contractual arrangements with physicians from established private practices.

A new and creative program to improve the geographic and specialty distribution of physicians is contained in section 201 of S.2378. This program would authorize grants to medical and osteopathic schools, as well as to hospitals, to meet the costs of innovative educational medical residency programs designed to encourage physicians to locate their practices in designated health manpower shortage areas. Such programs include support both for resident preceptorships in medically underserved areas and for faculty stipends for practitioners who are practicing in underserved areas, but who are not currently involved in residency training programs. In addition, this bill would make grants available to primary care residency programs to enable them to provide clinical training in such ambulatory health care facilities as health maintenance organizations and community health centers. Because this program could provide a much-needed link between the primary care medical education process and underserved communities, we strongly support it.

__Foreign Medical Graduates__

S.2378 would extend the "substantial disruption" waiver provision of section 212 of the Immigration and Nationality Act to December 31, 1985. It is our understanding that the Administration's bill will propose extension of the waiver for three years. Existing law permits teaching hospitals to request a waiver of certain provisions of the act which limit the participation of foreign medical graduates (FMGs) in U.S. graduate medical education programs if it is shown that exclusion of an alien medical graduate from the program through application of the requirements would cause a substantial disruption in the health services provided by the program. Under current law, this waiver provision expires December 31, 1980.

The AHA strongly supports this proposed extension. The availability of this waiver is of critical importance to certain major urban health institutions. As you know, many hospitals, both public and private, are experiencing severe financial difficulties as a result of the volume of uncompensated services provided to residents of urban areas without health insurance coverage or eligibility for public programs. Significant side-effects of this problem are the decreased ability of hospitals to retain medical staff and to maintain graduate medical education programs. As financial conditions worsen, salaries in these hospitals cannot keep pace, and the ability of the institutions to maintain the equipment and support services required by physicians in specialty practices becomes severely limited.

A recent __New York Times__ editorial noting that the termination of the substantial disruption waiver would intensify the hospital financial crisis in New York City stated that hospitals would be forced either to reduce services or incur further costs in attempts to attract U.S. physicians to replace the foreign physicians in training. Those most likely to suffer, the editorial concludes, would be the poor who rely on housestaff as their family physicians.

The AHA agrees that continuation of the waiver is not a long-term solution to the problem of physician shortages in medically underserved areas. Thus, we also support the additional provisions of S.2378 that would require the Secretary of HEW to identify areas of the country that are particularly dependent on FMGs and develop plans in cooperation with state and municipal governments to reduce dependence on such physicians. However, we firmly believe that the substantial disruption waiver should be continued as an interim measure, in order to afford those hospitals which require waivers sufficient flexibility to maintain needed services.

The AHA also supports the provision in S.2378 which would extend the length of time for which FMGs are permitted to come to the U.S. for training from the existing two years to seven years. The proposed change would recognize that many postgraduate programs require more than two years to complete.

Finally, we support the provisions of S.2378 that would (1) permit a National Health Service Corps scholarship recipient to fulfill his or her obligation by voluntarily performing his or her residency in a hospital where residency training programs are heavily dependent on FMGs and (2) designate a hospital with a heavy dependence on FMGs as constituting a highest priority health manpower shortage area for purposes of assigning corps personnel (and limit the cost-sharing obligation of the hospital in such a case to a salary equal to that which was paid to the FMG resident). We believe this approach would help to alleviate the problem of reliance on FMGs. In addition, it could encourage physicians to establish practices in underserved urban areas, thereby helping to ameliorate the chronic physician shortages in these localities.

Data Requirements

Accurate, comprehensive data on health manpower are fundamental to the development and maintenance of a meaningful national health manpower policy. The existing cooperative health statistics program was developed with this goal in mind. Unfortunately, uneven development and technical problems have limited the program's usefulness. While some states have excelled in data collection efforts, others have performed poorly, and still others have not participated at all. As a result, data are often incomplete or inaccurate, and meaningful comparisons or compilations cannot be made. Both public and private efforts to address manpower policy questions have been hindered by this problem.

Both S.2375 and S.2144 propose new initiatives in health data collection. S.2375 would require the Secretary of HEW to undertake or support a program to collect data biennially on health personnel in the states, including data on their training, licensure status, location of practice, and specialty, as well as personal information. In carrying out this provision, the Secretary would be instructed to collect available information from public and private entities. The Secretary could make grants and enter into contracts with public and private entities for the collection of information not otherwise available. The Secretary also would be authorized to provide technical assistance for the purpose of carrying out this program. S.2144 proposes a joint program between the National Center for Health Statistics and the Bureau of Health Manpower to collect data on health personnel, including a uniform health professions data reporting system. The Secretary would be authorized to collect such data from existing sources or through contract studies.

The AHA believes that any program of health manpower data collection must be supported by a commitment of resources from the federal government. This commitment is necessary to ensure a uniformity of effort. One of the most important additional resources that the federal government can provide is a strong technical assistance program to enable those states without adequate capabilities in the data field to acquire the necessary expertise; we recommend the inclusion of such a program in the Subcommittee's reported bill.

We would also point out that hospital-based manpower is one area of particular deficiency in existing health manpower data efforts. Federal and state programs have not focused on the need to identify and describe those practitioners who are located in the hospital setting and to determine requirements for such personnel. One result of this deficiency has been difficulty in determining, from existing data sources, the shortage of nurses in hospitals, in terms of the overall supply of nurses.

The AHA recommends that particular attention be given to this data deficiency. We further recommend that this data collection be accomplished in cooperation with the efforts of the private sector, including those of AHA. Existing expertise and data channels make such an alternative preferable to an independent public sector effort.

Advisory Councils

Both S.2375 and S.2144 would expand the membership and representation of the National Advisory Council on Health Professions Education. The AHA supports consolidation of all advisory functions, except nursing, under Title VII, with assurance of appropriate representation from all affected professional groups, educators, and the public. In addition, the AHA recommends that representatives of employers of health professionals be included on the council. This representation would provide a significant link between educational objectives and the employment marketplace.

CONCLUSION

On behalf of the AHA, I would like to thank this Subcommittee for the opportunity to present our views on pending health manpower proposals. We would be pleased to offer any further assistance, at your request, and to respond to any questions which you may have.

Senator **Schweiker**. Thank you.

We will put your whole statement in the record, and I would like to begin by first congratulating you for organizing a national commission on hospital nursing services. I hope it will begin its work expeditiously because there is much that needs to be done to increase the attractiveness of nursing and to improve hospital staffing patterns.

I would like to point out that you have taken the lead in this area and I commend you for it. You did mention in your opening statement the importance of hospital nursing schools.

Recently, I met with hospitals in my State of Pennsylvania and I was disappointed to find that their statistics indicate there is a decline in graduates in schools of this type. I wonder, No. 1, if you could tell us why and then, two, why this is such a serious trend as you obviously think it is.

Mr. **McMahon**. Well, Mr. Chairman, we are not sure why, and that is one of the reasons that we have set up this new commission. Probably like other complex problems it is an issue that has many sides. Certainly the development of other opportunities for nurses has caused the decline in nurses in the hospital setting.

The board of trustees of the AHA asked the nurses association to be careful about the implications of some of their positions that might tend to reduce the availability of nurses and the attractiveness of the hospital setting. Clearly, the opening up of other occupations to people who once went into nursing is part of it and it may well be that the articulation between nursing and other professions also makes a contribution.

We have seen the decline not only in the—slight decline in enrollment that we hope will not get any worse, but also a key decline in the applicant pool itself in our various hospitals with some implications again for the future. So we are concerned, we have seen a drop in the number of hospital schools of nursing. We must reverse this trend because we need nurses of all kinds but particularly from the diploma schools.

Senator **Schweiker**. In your statement, you elaborate further, pointing to a 2-percent decline, which is the first time in 10 years that fewer nurses were graduated than the year before and also a big drop of 16 percent between 1977 and 1978 in terms of applications to the RN program. I think that is really a pretty scary portent of things to come. My question is what is your experience with the ability of hospitals to improve salaries and working conditions to make nursing more attractive as opposed to using the bounty system?

You heard me use the bounty system? I am sure you are aware of the tool.

Mr. **McMahon**. Well, of course, we believe that the encouragement of nursing schools, nursing education and the opportunities for young women and now young men coming into the nursing profession with some help is an important part of it. If there are nursing shortages, if the nursing shortages continues, if it gets worse, we are going to be caught on the horns of a dilemma, that is the increasing costs that come about when we have to scrap for members of a profession in short supply.

I think that is one of the reasons that there have also been some problems in nursing. The pressure on hospitals and cost containment has markedly reduced their ability to finance nursing education and to enter into articulation programs with some of the educational institutions.

So we are going to catch it one way or the other and very clearly, as my testimony indicates, we come down on the side of nursing education rather than attracting people back in because we think the latter will probably be more costly.

Senator **Schweiker**. Right, which I gather is sort of the reverse of the administration because they want to go the other way or at least go halfway the other way, maybe not fully.

Mr. **McMahon**. That is clear which, of course, is not the first time we had some disagreement with the course of this administration.

Senator **Schweiker**. Right. Well, I can understand that.

Let me say we appreciate your testimony here and particularly your statistics and look forward to hearing your report on your national commission and the Senate Health and Scientific Research hearing will recess until our next hearing.

Mr. **McMahon**. Thank you, Senator Schweiker.

[The following material was subsequently supplied for the hearing record:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

The Honorable Howard Metzenbaum
United States Senate
Washington, D. C. 20510

Dear Senator Metzenbaum:

I am responding to your March 14, 1980 letter to Secretary Harris. I am pleased to submit for the record responses to the five questions that were enclosed with your letter and prompted by the Administration's proposal and testimony for the extension and modification of the health professions education legislation.

Please let me know if I can be of further assistance.

Sincerely,

William B. Welsh
Assistant Secretary
for Legislation

Enclosure

QUESTION 1: The American Hospital Association reports 90,000 to 100,000 vacancies for nurses in their 6,100 hospitals. The American Nurses' Association reports a 35% vacancy rate in nursing positions in community health agencies. Nursing homes report critical shortages of nurses. And yet the Administration's legislative proposal reflects the Administration's position that this country has an adequate supply of nurses. Why is there such a dramatic difference of opinion on this subject?

ANSWER: The Administration's legislative proposal reflects current data and projections that the overall supply of registered nurses is in balance with present requirements for nursing personnel and that no increase in the number of nurses being trained will be necessary to meet future demands. Perceived shortages of nursing personnel in certain types of facilities or geographic locations are not typically a function of supply and will not be eliminated simply by increasing the number of registered nurses. Since 1970 HEW has provided nearly $1.3 billion to train nurses.

Many of the factors leading to unfilled positions for nursing personnel cannot be addressed by Federal legislation. These factors include lack of career ladders, lack of flexibility in scheduling hours, night and shift work without adequate salary differentials and low salaries and fringe benefits. Family responsibilities remove many licensed registered nurses from the labor market. Others find that promotion opportunities are limited and seek employment in other fields. We would encourage the private sector to affect changes in these areas.

We believe that targeted special project aid can be of some assistance in the alleviation of nursing shortages caused by geographic maldistribution, lack of appropriately trained personnel, and inadequate retraining programs for inactive nurses seeking to reenter the labor force. Thus, the Administration's proposal would authorize support of programs to train needed specialists such as geriatric and pediatric nurses; increase educational opportunities for individuals from disadvantaged backgrounds; provide continuing education, retraining, and inservice training; provide training for nurses to improve geographic and specialty distribution; and provide advanced training.

The Administration has also proposed to expand the access of nurses to National Health Service Corps scholarships and HEAL loans. These proposed changes along with the funds requested for fiscal year 1981 for Department of Education programs for which nursing students are eligible will assure nursing students access to financial aid on the same basis as all other undergraduate health professions students.

QUESTION 2: The Administration's legislative proposal primarily addressed medicine. Have you made the policy decision that the other health professions no longer need Federal funds to solve their problems, particularly in dentistry, podiatry, pharmacy, optometry, veterinary medicine, and all of the allied health professions?

ANSWER: The Administration assigns the highest priority at this time to the development of more primary care health personnel to serve in shortage areas. We see the most immediate area of need as being the development of more primary care physicians, which we would accomplish by expanding training programs in family practice and general internal medicine and general pediatrics. In addition, we would continue to support training for midlevel primary care practitioners such as nurse practitioners and physician assistants. There is, however, no need to continue Federal funding merely to increase the supply of health professionals.

The Administration would continue to provide separate categorical support for training of dentists in the organization and management of multiple auxiliary dental team practice. This program is felt to have a crucial contribution to make toward the improvement of efficiency in dental practice.

To meet other pressing needs for Federal intervention in the dental, VOPP, and allied health fields, we would rely on the proposed special project authority. In fiscal year 1981 the President's budget would focus aid under this authority largely on public health training. However, as needs arise in other fields, they could be addressed in future years.

QUESTION 3: What has been the impact of the National Health Service Corps to date in meeting the needs of underserved populations and in solving geographic distribution problems?

ANSWER: Today the NHSC is the principal vehicle for meeting the primary health care needs of persons whose needs would not otherwise be served. The number of people who rely on Corps personnel for their continuing health care [illegible] from 58,000 in 1972 to about 1.3 million today. These are people who before the program was enacted had no regular physician.

The Corps has grown to 1,850 personnel on duty in 820 remote rural areas, small cities and poor urban centers where most doctors have not chosen to serve and are not likely to do so in the future.

QUESTION 4: How many people are living in areas being served by the National Health Service Corps? To what extent would they have access to health services if the Corps did not exist?

ANSWER: While we are unable to tell how many people are living in areas being served by the Corps, we estimate a total service capacity of 1.3 million people for the existing sites.

Since priority for placement of NHSC providers is to the neediest areas, the people living in these areas would not have adequate access to services if the Corps were not there.

QUESTION 5: Under the Administration's plan there will be 7,200 physicians in the Corps by 1990, and yet, this field strength will meet only 47 percent of the need stated in your testimony. How do you propose to deal with the shortfall?

ANSWER: The Administration's policy is that a physician field strength of 7,200 is an appropriate planning base for the 1990's.

Estimates for ten years or more in the future are subject to substantial uncertainty and differences in judgment, e.g., whether the National Health Service Corps should be used to staff State prisons and mental institutions and the appropriate physician to population ratios. In addition, much of the potential need for the NHSC is expected to be met with other resources. We estimate that 12 percent of the possible need would be met by physicians employed by Federally funded health centers. Although the situation may change, we anticipate that much of the remaining [illegible] percent of need could be met by changes in physician distribution, improved financial access from proposed expansions of health care financing programs, and by State and local governmental efforts.

The need estimate for the NHSC will be reassessed annually during the budget process and adjustments in planned field strength will be proposed as they are warranted by more refined analysis or future developments.

aamc association of american medical colleges

202: 828-0400

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

March 26, 1980

Honorable Edward M. Kennedy
Chairman, Subcommittee on
  Health and Scientific Research
Committee on Labor and
  Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

The Association of American Medical Colleges (AAMC) would like to take this opportunity to express its appreciation for the opportunity to testify on the various proposals to renew P.L. 94-484 before your Subcommittee on March 10, 1980.

Enclosed, for your information, are several additional documents that the AAMC wishes to enter in the hearing record. During the rapid exchange at the hearing, it appeared to the Association that certain important facts did not emerge clearly; thus, the AAMC is taking the liberty of transmitting some material which it believes will be useful in clarifying selected portions of the record:

- Applicant Data 1973-1980 (Attachment I)
- Change in Capitation and Tuition 1972-1980 (Attachment II)
- Loan Repayment Data (Attachment III)
- Minority Enrollment (Attachment IV)

If you or other members of the Subcommittee desire further information on these or any other issues related to the renewal of the current health manpower law, please do not hesitate to contact me. I and members of my staff stand ready to assist the Subcommittee in any way possible.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Enclosures

cc: Members of the Subcommittee

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

Attachment I

Applicant Data 1973-74 - 1979-80

The attached table (Ia) provides summary information on applications to U.S. medical schools from 1973-74 through 1979-79. The most notable trend apparent from the table is the continual drop in the number of applicants from the peak of 42,624 in 1974-75 to 36,141 in 1979-80, a fall of 15% in a five year period. This substantial decline in the size of the pool, coupled with an increase of 1800 first year places, increased the acceptance rate from 35% in 1974-75 to 47% in 1979-80.

Current speculation about the cause of this decline include among others the following:

- The size of the applicant pool has dropped because of the high cost of medical education.
- Medical education is increasingly becoming a realistic career aspiration for only the affluent members of our society.
- There is a perception that there are inadequate student assistance funds available to meet the needs of all medical students. Students are unwilling to "indenture" themselves for service in the NHSC or to assume responsibility for the repayment of unmanageably large debts upon the completion of their training.
- Medicine is becoming increasingly less attractive as a career because of the growing penchant on the part of the Federal Government and private insurors to control the career choices and professional activities of physicians and to regulate the institutions and

individuals engaged in the delivery of health care.

- With opportunities galore for bright students, especially those from minority groups, in other fields, competition for medical careers is slackening.

Not only is the size of the applicant pool declining, but it is worth noting that the characteristics of medical school aspirants are changing as well. Table Ib shows the income distribution of all families with students in college and the income distribution of families with students in medical school. While the distribution of college students family incomes between 1970 and 1977 has remained relatively stable, the change in medical student's family incomes over the same seven year span has been dramatic with a significant increase in the number of medical students from families with incomes over $25,000. This data has obvious implications for the development of the student assistance portion of the health manpower legislation. There is a real need for adequate funding to support students from low and middle income families if the medical school population is to remain economically heterogeneous.

Table Ib

INCOME DISTRIBUTION OF ALL FAMILIES WITH 18-24 YEAR-OLD MEMBERS ATTENDING COLLEGE FULL-TIME, 1970 and 1977

1970 FAMILY INCOME* (Constant 1977 $s)	PERCENT OF FAMILIES IN INCOME LEVELS 1970	1977	1977 FAMILY INCOME
Under $15,605	37.1	34.1	Under $15,000
$15,605 - $23,409	31.0	33.1	$15,000 - $24,999
Over $23,409	31.8	32.9	Over $25,000

INCOME DISTRIBUTION OF FAMILIES WITH MEMBERS ACCEPTED TO MEDICAL SCHOOL, 1970 and 1977

1970 FAMILY INCOME* (Constant 1977 $s)	PERCENT OF FAMILIES IN INCOME LEVELS 1970	1977	1977 FAMILY INCOME
Under $15,605	24.4	22.9	Under $15,000
$15,605 - $23,409	42.6	28.3	$15,000 - $24,999
Over $23,409	33.0	48.9	Over $25,000

*Income data are only collected in intervals. When constant dollar adjustments are made, it is not possible to align income intervals to make exact comparisons between years.

Attachment II

Change in Capitation and Tuition Between 1972 and 1980

The attached Table (II) indicates that between 1972 and 1980, capitation has declined by $1315 in real dollars and by $1635 in constant dollars. An examination of the increase in tuition over that same period of time indicates that in 1972 dollars, the tuition of private schools has increased by slightly over $1000, while for public schools, resident and non-resident tuition has increased by $76 and $381 respectively. Thus for neither public nor private institutions has tuition increased to the same degree capitation has decreased.

Schools establish tuition levels according to a number of criteria, and loss of funding from other sources is only one factor. It is clear that even among those private institutions that have the flexibility to increase tuition, the increases have not been sufficient to compensate for the loss of capitation. Instead, the schools have obtained funds from other sources and held down costs, in an effort to maintain access to medical education for students from less affluent families.

Table II

CHANGE IN CAPITATION AND TUITION BETWEEN 1972 AND 1980

	Capitation Per Medical Student		Tuition					
			Private Schools		Public Schools			
					Resident		Non-Resident	
FY	Actual	Adjusted*	Actual	Adjusted*	Actual	Adjusted*	Actual	Adjusted*
1972	2065	2065	2400	2400	767	767	1565	1565
1975	1585	1250	2900	2280	909	715	2000	1573
1980	750	430	5994	3431	1473	843	3400	1946
Increase or Decrease from 1972-1980	-1315	-1635	+3594	+1031	+706	+76	+1835	+381

*Adjusted for 1972 dollars.

Attachment III

Loan Repayment Program

There seems to be conflicting data regarding the Loan Repayment Program. According to Dr. Edward Martin, Director of the Bureau of Community Health Services, in his testimony before the Senate Subcommittee on Health and Scientific Research, the Loan Repayment Program has not been very successful. Dr. Martin reports that out of 8000 eligible students only 300 (4%) actually took advantage of the program. According to a 1978 GAO study entitled, Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas as of October 31, 1977, only 1.7% of those eligible participated in the program. HEW estimated that the average indebtedness of those participating was $8100.

Recent reports would indicate, however, that the loan repayment program has become increasingly popular. In FY 1979 the Federal appropriation for the loan repayment program was $1.5 million. According to officials responsible for administering the program, nine to ten million more was needed to meet the demand for participating in the program in that year alone and thus, it was necessary to cut off applications. While the information conveyed to the Subcommittee may well be correct, it seems that the information is probably somewhat out of date and did not take cognizance of current trends.

As the attached three tables indicate, debt levels are rising at a very rapid rate. According to the 1979 AAMC Graduation Questionnaire approximately 75% of the respondents had school debts which averaged $15,900. Thirty percent of these had accumulated indebtedness in excess of $20,000 and 10% owed $30,000 or more.

Compared with reports from the class of 1978, all of these figures reflect substantial increases. Moreover, the 1979 figures are substantially higher than the average debt levels ($8100) of the 1977 participants in the Loan Repayment Program.

Based on current trends the AAMC would urge that serious attention be paid to the Loan Repayment Program and that the Subcommittee consider it as a major component of its student assistance package.

Table IIIa

Indebtedness of Senior Medical Students in Public and Private Schools for 1977-78 and 1978-79

	Percent of All Students*			
	1977-78		1978-79	
Amount	Private	Public	Private	Public
Under 10,000	33.1%	46.1%	23.1%	37.0%
10,000-20,000	35.2%	35.8%	37.2%	38.1%
20,001-30,000	21.3%	15.1%	26.7%	17.2%
30,001 up to 45,000	7.9%	2.2%	10.5%	6.0%
45,000 and over	2.5%	.8%	2.5%	1.7%
	100.0%	100.0%	100.0%	100.0%

* Based on a representative sample

Table IIIb

Average Indebtedness of Graduating Seniors in Public and Private Medical Schools for 1977-78 and 1978-79

1977-78		1978-79	
Private	Public	Private	Public
$16,118	$12,098	$17,973	$14,382

Table IIIc

THE INDEBTEDNESS OF GRADUATING MEDICAL STUDENTS

Data on student indebtedness demonstrate that during the 1970's the debt load of graduating seniors increased dramatically. These data were derived from representative sample surveys conducted by the AAMC in 1971, 1975, 1978, and 1979. The 1978 and 1979 data are corroborated by another questionnaire to which approximately 8,000 seniors responded each year.

Table A shows that 72% of graduating seniors reported that they were in debt in 1971. The average debt was $5,500. In 1979, 76% of the seniors were in debt and the average debt level was $15,800 (an increase of 187.3%). In a single year between 1978 and 1979, the average debt level increased by 14.5%.

TABLE A

AVERAGE INDEBTEDNESS OF GRADUATING SENIORS

Year	Percent of Seniors Reporting Indebtedness	Average Indebtedness
1971	72%	5,500
1975	71%	9,000
1978	76%	13,800
1979	76%	15,800

Percent Change in Average Indebtedness

1971 - 1979	187.3%
1978 - 1979	14.5%

This trend of growing indebtedness is of great concern. Table B shows that the proportion of graduating seniors with debts of $20,000 or more increased from 23.9% in 1978 to 30.7% in 1979.

TABLE B

INDEBTEDNESS OF GRADUATING SENIORS FOR 1977-78 AND 1978-79

	Percent of All Students*	
Amount	1977-78	1978-79
Less than $10,000	40.6%	31.5%
$10 - 20,000	35.5%	37.8%
Over $20,000	23.9%	30.7%
	100.0%	100.0%

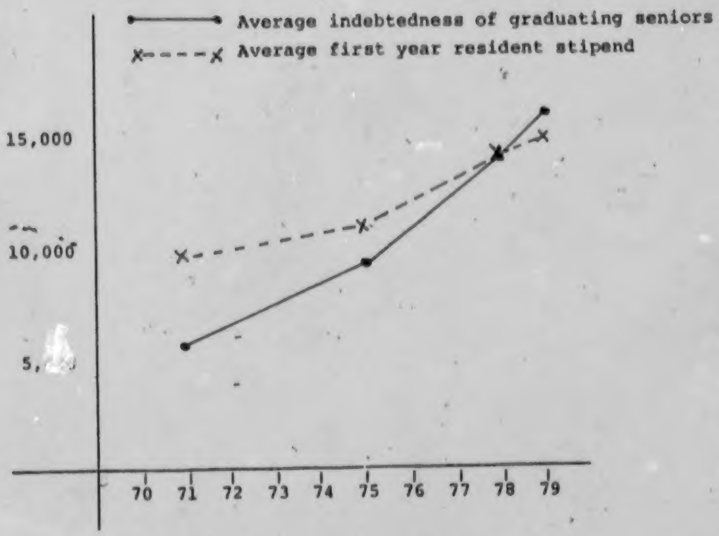
*Based on a representative sample

The effect of such levels of indebtedness on students' ability to continue their education through residency training and its effect on career plans and specialty choice can only be speculated upon at this time. However, Table C demonstrates that the average indebtedness upon graduation is now in excess of the first year resident stipend. In 1971 seniors graduated with average indebtedness that was only 67% of the stipend they might expect as a first year resident. In 1979 average indebtedness was 6% greater than the average first year stipend.

Table C

TREND IN AVERAGE INDEBTEDNESS OF GRADUATING SENIORS VS. AVERAGE FIRST YEAR RESIDENT STIPEND

	Average Graduate Indebtedness	Average First Year Resident Stipend
1971	5,500	9,200
1975	9,000	11,700
1978	13,800	13,900
1979	15,800	14,800



Attachment IV

Minority Enrollment

Dr. Foley in his remarks before the Senate Subcommittee states the following:

> "I think we need to get out to the minority population in this country as well as the majority, the type of income that physicians make in this country and look at that and sit down with the physicians, the bankers to see if there is a way that these types of tuitions and student support can be financed because clearly it is a very profitable enterprise to enter."

There is an implication in Dr. Foley's statement that minority students are not cognizant of the income potential of physicians and this is the reason there are not a greater number of minority applicants. While the AAMC cannot disagree with such an assumption, the Association must emphasize that lack of information is not the only reason for low minority enrollment. Mr. Andrew Young, former U.S. Ambassador to the U.N., supports this viewpoint. In his keynote address to the Minority Affairs section at the 1979 AAMC Annual Meeting, Mr. Young clearly stated that in his view the medical schools could not be blamed for the small number of minority students enrolled in medical school. Those qualified students that do in fact apply to medical school are admitted. The real problem is getting minority students to consider medicine as a career and with the opportunities available to them in other fields--which often will pay very lucrative salaries to attract competent individuals and require a much shorter and less expensive education--many minority students never give medicine a serious look.

The AAMC strongly supports the position of the Subcommittee that adequate student assistance must be available for minority students to consider medicine a viable career option. On the other hand, the AAMC wants the members of the Subcommittee to recognize that available student assistance alone will not solve the problem of a shortage of minority physicians.

aamc association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

202: 828-0400

April 3, 1980

Honorable Edward M. Kennedy
Chairman, Subcommittee on
Health and Scientific Research
Committee on Labor and
Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Enclosed are the Association's comments on the Administration's health manpower proposal, H.R. 6800, the "Health Professions Education Amendments of 1980" which were requested by Senator Metzenbaum at the Subcommittee's March 10 hearings.

If I or members of my staff can be of further assistance to the members of the Subcommittee, please do not hesitate to contact us.

Sincerely,

John A.D. Cooper, M.D.

Table Ia

SUMMARY OF INFORMATION ON APPLICATIONS TO U.S. MEDICAL SCHOOL, 1973-74 THROUGH 1978-79

First Year Class	No. of Medical Schools	No. of Applicants	Accepted Applicants	Percent of Total Applicants Accepted
1973-74	114	40,506	14,335	35.4
1974-75	114	42,624	15,066	35.3
1975-76	114	42,303	15,365	36.3
1976-77	116	42,155	15,774	37.4
1977-78	119	40,569	15,977	39.4
1978-79	126	36,636	16,527	45.1
1979-80	126	36,141	16,880	46.7

AAMC's Comments on the

"Health Professions Education Amendments of 1980", H.R. 6800

Student Assistance Provisions

H.R. 6800 retains many of the elements of the student assistance structure envisioned by P.L. 94-484; the Association is pleased to note that the Bill makes an effort to address aspects of these programs that have proven to be troublesome in the implementation of the 1976 statute. The AAMC's comments will discuss each of the student aid programs incorporated in H.R. 6800 separately.

Health Education Assistance Loans (HEAL).

H.R 6800 proposes to retain, with important modifications, the HEAL program established under P.L. 94-484. This program has proven to be unpopular with borrowers and lenders alike. For the student, restrictive terms limit access to the loans and allowable uses for the borrowed funds, but the biggest deterrent is the heavy repayment burden ---a student borrowing $32,000 is liable to repay a total of $148,709 over a fifteen year repayment period. For the lender, the 12 percent interest ceiling is prohibitively low under market conditions experienced in the recent past and those portended for the near future. To date, only about $13 million has been borrowed under this program, approximately $5 million of which has been lent to medical students.

H.R. 5800 would modify the program embodied in the present statute by eliminating some of its more troublesome features, but does not propose changes adequate to address the problems currently experienced in the operation of the HEAL program. However, the AAMC is particularly pleased to note that the Bill eliminates the language preventing HEAL borrowers from access to loans under the Guaranteed Student Loan Program. In addition, the Administration proposes other desireable modifications. It would:

- Remove the 12% interest ceiling.
- Stipulate that the Secretary may not insure a HEAL loan made to an individual who has already defaulted on a previous HEAL or GSL loan.

The AAMC believes that, while these provisions represent an improvement over current law, they are not sufficient. The restriction that no more than 50% of each school's students can receive HEAL loans should be eliminated. It is also necessary to liberalize the deferral provisions and to modify the program to ease the repayment burden.

It is the AAMC's view that the incorporation of these modifications is essential in order to make the HEAL program more viable. In addition, the Association believes that it is necessary to raise the borrowing limit under this program to increase allowable expenditures to include reasonable living expenses. A rapidly escalating inflation rate approaching 20% per annum accompanied by commensurate increases in tuition require such an increase in order for students to meet the costs of their education.

While the Association believes that this program has been and would be useful to a student only as a last resort, it feels that these modifications would go a long way towards eliminating the problems engendered by the specifications presently embodied in P.L. 94-484.

Health Professions Student Loan (HPSL) Program.

The HPSL Program was designed to increase the access of needy students to health professional careers. The Administration bill does not reauthorize this program, nor does it propose an alternative. The Association is disturbed and puzzled by the Administration's decision in light of the program's success from the perspectives of both the students and the schools. For academic years 1977-1978 and 1978-1979 respectively, awards to 10, 926, and 9,808 medical students were made under this program. The 1978 Report of the AAMC Task Force on Student Financing found that the HPSL program was an important factor in minimizing the debt burden on economically disadvantaged students and concluded that:

> "The HPSL program will help insure that the consequences of the apparent Federal policy of having medical students pay for a larger share of their educational costs does not fall disproportionately upon the economically disadvantaged student, therefore effectively further limiting access to medical school for these students."

Also of concern to the Association is the Administration's decision to retain Section 742 (b) which mandates that the Federal Government recover, by the end of FY 83, the HPSL capital funds currently available to the schools. The Association is convinced that leaving the revolving HPSL funds in the schools would create a permanent loan fund that would constitute a sound means, both from an economic and a public policy perspective, of financing assistance to students.

Exceptional Financial Need Scholarships (EFN). Under P.L. 94-484, only first year students in exceptional financial need---those students with virtually no financial resources---qualify for this program; recipients receive tuition, fees, and a living stipend of approximately $5,500 per year, and incur no service obligation. This program has been praised in concept, but its implementation has drawn criticism. The 1978 report of the AAMC Task Force on Student Financing pointed out that: the definition of "exceptional financial need" as zero financial resources is unreasonably restrictive; scholarship support for only one year is inadequate and should be expanded to two years; and appropriations for the program have been inadequate.

It is the Association's view that the program meets an important social need; retention of this program in H.R. 6800 indicates cognizance of this fact. However, modification of the definition of exceptional financial need to include a larger number of needy students and expansion of the period of support to two years would strengthen its viability and effectiveness. It is important to note that under the present definition of exceptional financial need, still only about 4% of the entering class of approximately 17,000 students would qualify for this program. Moreover, the authorization levels proposed by H.R. 6800 for this program are inadequate.

National Health Service Corps and the NHSC Scholarship Program. H.R. 6800 proposes to reauthorize the NHSC Scholarship Program at essentially its current level of appropriations and to reauthorize the NHSC at a considerably higher level. There is a growing consensus that this scholarship program has become progressively less focused on service to ameliorate the problems of geographic and specialty maldistribution and has become de facto student assistance---attracting individuals with little *bona fide* interest in the primary objective of the Corps. There is also growing concern that it has come to represent a very expensive solution to the maldistribution problems afflicting the Nation.

This state of affairs is reflected by the proposal in H.R. 6800 to modify the Corps and the Scholarship Program to promote greater cost-effectiveness. The Administration bill would eliminate the income equivalence test for the Private Practice Option to encourage its use and thus decrease the number of Corps personnel on the Federal payroll. The AAMC believes that this would be a desirable modification since, to date, only a handful of physicians have utilized this option.

The Administration Bill also seeks to amend Title VII to establish a program of cooperative agreements with the States to alleviate health manpower shortages. Under this proposal:

- The States would be responsible for developing a State plan for reducing the geographic maldisturbution of health professionals.
- States providing "substantial State financial support" for health professions placement programs designed to alleviate geographic maldistribution problems would be accorded priority in the assignment of Corps personnel.

As outlined in the Bill, it is difficult to discern exactly how this program would operate. Presumably, its purpose is to encourage the States to assume more of the responsibility for the solution of health manpower shortages within their own boundaries. While the AAMC believes this goal is desirable, it is not persuaded that the solution proposed will achieve it; the economic burden it places on the States has not been adequately explored. Further study on the willingness of the States to participate in this program is necessary prior to its establishment in statute.

Regardless of the pros and cons of the proposed modifications, the AAMC is uncertain that these changes would adequately address most of the concerns about the effectiveness of the Corps and its feeder, the Scholarship Program. Moreover, the AAMC is firmly convinced that it is time to assess the proposition that student assistance should be decoupled from programs to ameliorate maldistribution problems. These problems are discrete and individual solutions are more appropriate.

Alternatively, the AAMC suggests that: should loan programs become the principal instrument for student financial assistance, national service needs might well be met by loan forgiveness for individuals who volunteer either for private practice in underserved areas, or, if necessary, for a scaled down National Health Service Corps, or who enter academic research careers. The Association considers past experience with loan forgiveness as largely irrevelant in consideration of these proposals. In the past, these programs were unsuccessful, because the debts involved were on a much smaller scale than those presently incurred by medical students and were easily repayable in cash rather than in service. Clearly, the situation has changed: indebtness with which students are now saddled upon graduation is substantial and growing. Service as a mechanism for repayment will become an attractive option.

In summary, the NHSC and the NHSC Scholarship Programs have now been in operation for a sufficiently long period of time to permit an assessment of their effectiveness and cost and to evaluate their usefulness in comparison to other possible alternatives. The Association would therefore suggest that this statute not modify the programs in any substantial way, but instead mandate a careful study of these programs, in comparison to alternative approaches to the solution of the problem of geographic redistribution of physicians and medical service for underserved populations.

One final comment on the National Health Service Corps: The Association considers the Corps program as a single entity with a scholarship provision to secure the commitment of students to dedicate a period of their future career to public service and a provision for distributing those committed when they have completed training. These programs should be administered within a health component (HSA) of the DHHS and the funds for both should be included within the authorization ceilings for health programs. With the transfer of the scholarship programs from the HRA, its costs should not be charged against the authorization ceilings for health education programs.

Institutional Support

The Association is deeply disturbed to note that institutional support for schools of medicine is conspicuously absent from H.R. 6800. The AAMC's view of this issue is well known; for a detailed explication of the Association's position on the critical nature of institutional support and the consequences of its demise, the Subcommittee is referred to pages 22 through 26 of the AAMC's Statement for the Record submitted to the Subcommittee on March 10.

Special Project Grant Programs

H.R. 6800 revamps the special project grant authority under current law. It proposes to retain several of the elements of P.L. 94-484 and proposes to repeal a number of others including authority for start up assistance, project grants for occupational health training and education centers, general practice of dentistry, and cooperative interdisciplinary programs. H.R. 6800 would also eliminate the current list of special projects in Section 788 and instead states that projects may include but are not limited to projects for health and health administration training.

While the catalog of special projects listed in H.R. 6800 reflects a comprehensive view of activities currently in the public interest, the Association would suggest the possibility of including several additional items in the Special Project Grant Program:

- The development of a special training program for women and minorities interested in careers in academic medicine.
- A training program for residents on practice management, with an emphasis on cost containment in private practice.
- The creation of a program or series of activities to encourage students and residents to consider academic research careers.
- The development of programs to satisfy the needs of physicians in rural or underserved areas for interaction with faculties of academic medical centers and for current information on scientific advances in selected specialty areas.

Institutions in Financial Distress

The Association supports the separate financial distress authority provided for in H.R. 6800 rather than other proposals which would subsume it within an amalgamation of other authorities.

Predominantly Minority Institutions

There are new as well as established medical schools whose student bodies are comprised predominantly of individuals from minority groups, drawn from all over the country. As private institutions, they have very limited call upon state support. While these schools have benefited to some extent from philanthropy, minorities are not substantially represented among the philanthropists who have made major gifts to non-minority private schools from their long established large family fortunes. Thus, these schools, which play so important a role on the cutting edge of highly desirable social change, must depend heavily on the Federal Government for support. The AAMC urges the Congress to give sensitive attention to their plight.

Foreign Medical Graduates (FMG) Provisions

The Administration bill proposes changes in legislation related to foreign medical graduates (FMG's) in, or coming into, the United States for graduate medical education under the student exchange (J-Visa) provisions of the Immigration and Nationality Act (INA).

Under the provisions of H.R. 6800 the requirement to pass the Visa Qualifying Examination (VQE) as a condition for receiving a J-Visa would be waived until December 31, 1983 under circumstances in which its imposition would substantially disrupt the health and medical services provided by the hospitals in which the graduate medical education of these physicians took, or was to take place. It is the Association's view that adoption of this proposal would be a grievous setback for the long-standing efforts of this country's medical education enterprise to improve graduate medical education and the care delivered to the underserved and disadvantaged populations of this Nation.

One of the most significant changes to the INA that occurred with the passage of P.L. 94-484 was the institution of a requirement that J-Visa holders whould have to pass the VQE rather than the ECFMG examination. The purpose of this modification by the Congress in 1976 was to raise the educational achievement standards for FMG entry into the U.S. for graduate medical education, and thereby to protect the American public from contact with inadequately educated physicians serving as hospital residents. The current statute requires that, as of January 1, 1981, all FMG's coming to the U.S. for training will have passed the VQE; until then, institutions can file for a waiver of this VQE requirement, on the ground that there would be "substantial disruption" of medical service if FMG's on the staff of an institution were required to have passed this examination.

The AAMC recognizes that a few hospitals in this country, particularly in SMSA's such as New York City, are faced with severe problems in recruiting USMG's for their residency programs. Nonetheless, the issue is no different today than it was when P.L. 94-484 was passed in October, 1976. If "substantial disruption" waivers are continually granted, these hospitals which have had four years to correct their deficiences will postpone confronting the real problem -- the quality of the graduate medical education offered and the consequent inability of the program to attract graduates of U.S. medical schools.

The AAMC does not take pleasure in appearing to be unsympathetic to the needs of these distressed hospitals. But it is equally distressed by the fact that a substantial segment of the least advantaged American citizens who live in the affected areas and who depend on these hospitals almost exclusively for their medical care, must rely on physicians who cannot pass an examination so designed that 95% of U.S. medical graduates would be expected to pass. Current practices -- apparently little different than those prevailing before the enactment of P.L. 94-484 -- are not a socially acceptable, let alone an ideal, solution to even the medical care aspects of this problem.

The Association must, however, regard this as an education, not a health care, issue. In this context, it is persuaded that, if the directors of those graduate medical education programs and the medical schools with which they are affiliated were forced to focus attention on the quality of the training programs, the dependence of these programs on FMG's would rapidly diminish. In the same institutions that request waivers for some of their programs, graduate medical education programs in other departments have been strengthened and now attract graduates of United States medical schools or qualified foreign medical graduates.

It is also important to recognize the well nigh heroic dedication of the staffs of these hospitals in meeting the crushing workload that descends upon their institutions from the abandoned peoples of poverty devasted inner city slums. This load will not go away and devices must be found to handle it. To a large extent, the problem is economic. There can be little doubt that resident physicians are traditionally willing, even eager, to put in long hours in exchange for a quality education experience. To make the education experience meaningful and attractive to qualified medical graduates and to provide adequate supervision of the medical services provided in the institution, additional numbers of attending staff are necessary; this would cost money.

The Association and its members can contribute to the solution of the educational problems that are in this area, but that contribution provides too narrow a perspective on an immense social and economic problem. The Congress is urged to examine this issue in all of its dimensions and to ponder the ramifications of this apparently minor amendment to extend the period during which the VQE requirement could be waived. In the opinion of the Association, such an action is not in the best interest of education, of medicine or of the urban poor. The latter deserve, and ought to be provided a better solution than is contemplated by this provision. We are faced with a political crisis. H.R. 6800 proposes only a totally inadequate and inappropriate solution, based on misuse of educational programs.

Senator SCHWEIKER. The hearing in now adjourned.

[Whereupon, at 12:18 p.m., the subcommittee adjourned, subject to the call of the Chair.]

HEALTH PROFESSIONS EDUCATION AND DISTRIBUTION ACT OF 1980

WEDNESDAY, MARCH 12, 1980

U.S. Senate,
Subcommittee on Health and Scientific Research,
Committee on Labor and Human Resources,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:04 a.m., in room 4232, Dirksen Senate Office Building, Senator Howard M. Metzenbaum presiding pro tempore.

Present: Senators Metzenbaum, Schweiker, and Javits.

Staff present: Rhonda Friedman, Robert Wenger, Robert Knouss, Steve Grossman, and Barbara Green.

Senator **Metzenbaum**. Today we will hold our second day of hearings on the issue of health professions training. We will hear testimony from Dr. William Danforth and Dr. Robert Marston, who will comment from the university perspective.

We will then have a series of witnesses addressing health professions training and public health and health administration and allied health. Mr. Michael Gemmell, Dr. Gary Filerman, and Dr. Lee Holder will speak to these issues.

Our third panel will include witnesses from the nursing profession, including Dr. Hazel Blakeney, Dr. Carolyne Davis, Dr. Rose Chioni, Mr. Russell Perry, and Ms. Louise Esiason.

The Chair wishes to announce that I will have to leave in the middle of the morning, but Senator Schweiker will continue with the hearing for the balance of the morning.

We are very happy to have you with us today, Dr. Danforth. We have a long list of witnesses, and we have attempted in the past to ask each of the witnesses to make every possible effort to conclude his testimony in 5 minutes and put the balance of the testimony in the record to leave some time for questions from those of us on the committee. Even under those circumstances, it is going to be a long morning.

Senator Schweiker, ranking minority member, has a short statement. We are happy to hear from him. He certainly has been a strong leader in this field. He has tremendous experience and has been extremely helpful over the years to Senator Kennedy, who is, as you well know, the chairman of this subcommittee. I am just sitting in in his absence.

Opening Statement of Senator Schweiker

Senator **Schweiker**. Thank you very much. I appreciate your chairing these 2 days of hearings on this very important subject.

I would like to welcome the very distinguished set of witnesses that we have for today's panels. On Monday, I mentioned in my opening statement the highlights of S. 2144 and some commentary on the need for realistic expectations with regard to health manpower legislation. Today I would like to speak for just a few minutes on the problems of nursing. Later in the morning I look forward to hearing from a panel of five groups representing various points of view within the nursing community.

The obvious starting point is whether or not there is a nursing shortage within the United States. The administration has consistently stated that there is a surplus! This is despite the reports from all over the country of nursing vacancies and of hospitals offering bounties for new nurses.

When questioned, even the administration admits that their position is based on gross numbers and not actual supply and demand. Thus I feel comfortable in dismissing the allegation that there is a surplus and instead believe the reports that there is a shortage.

However, it is important to isolate the causes of the nursing shortage. I can think of at least four such causes:

First, the increased demand for nursing services as a result of more extensive and sophisticated utilization of hospitals and extended care facilities;

Second, the relative unattractiveness of nursing because of low wages, irregular hours and poor working conditions;

Third, the decrease in the pool of 18-year-olds from which nursing schools can recruit; and

Fourth, the large number of career options now readily available to women which were closed or very limited in years past.

These four factors are causes of the nursing shortage and must be confronted by the nursing and hospital communities. It is a challenge to them to make nursing a more attractive profession; to further broaden recruitment efforts. This includes getting more men interested in nursing careers and developing more efficient staffing patterns for nurses.

These are areas in which the Federal Government can play only a secondary role. Leadership needs to be coming from those most affected. Thus, I was pleased on Monday to hear that the American Hospital Association has formed a National Commission on Hospital Nursing Services. I hope today we will learn more from the nursing community about their efforts.

I have started a dialog within Congress and among constituent groups about the pressing problems facing the health professions, including nursing. In the weeks ahead, I hope our committee will find a realistic and fiscally responsible approach to help solve these problems. Although we cannot do everything that needs doing, I pledge my support to find the best solutions.

Thank you.

Senator **METZENBAUM**. Thank you very much, Senator Schweiker.

Dr. Danforth, we are happy to hear from you and, of course, we have a special welcome for you as brother of one of our distinguished Members.

STATEMENTS OF WILLIAM H. DANFORTH, M.D., CHANCELLOR, WASHINGTON UNIVERSITY, AND ROBERT Q. MARSTON, M.D., PRESIDENT, UNIVERSITY OF FLORIDA, REPRESENTING THE ASSOCIATION OF AMERICAN UNIVERSITIES, NATIONAL ASSOCIATION OF STATE UNIVERSITIES & LAND GRANT COLLEGES, THE AMERICAN COUNCIL ON EDUCATION, AND THE AMERICAN ASSOCIATION OF STATE COLLEGES & UNIVERSITIES, A PANEL

Dr. **Danforth**. Thank you, Mr. Chairman.

Mr. Chairman and Senator Schweiker, I am William H. Danforth, chancellor of Washington University and chairman of the joint committee on health policy of the Association of American Universities, the American Council on Education, and the National Association of State Universities & Land Grant Colleges.

With me is Dr. Robert Q. Marston, president of the University of Florida and cochairman of the joint committee. We are grateful for the opportunity to present our views on the critically important health manpower legislation. We are pleased with the care and thought that have gone into the preparation of S. 2375 and S. 2144, sponsored separately by the chairman and ranking minority member of this subcommittee. We are aware of Senator Javits bill, S. 2378, but have not had the opportunity to review it fully.

Let me begin by telling you about our joint committee. It has been organized by university presidents and chancellors, including President Harold Enarson of Ohio State, because we are convinced of the importance of health education as our institutions do their best to serve society and because we wanted a coordinated, total university response to a complex series of challenges. We became convinced that the pulls and tugs of various worthy programs and projects were threatening the academic and fiscal integrity, and even the coherence, of the total institutions. We noted the multiple impacts on our institutions of uncoordinated policies of different Federal agencies.

For example, the health education sector is buffeted almost simultaneously by cutbacks in capitation, failure of research funds to keep pace with inflation, decreases in research training funds, discrimination against medical school physicians in reimbursement policies, unrealistic ceilings on payments to teaching hospitals, and inadequate reimbursement of overhead costs on Federal projects. At the same time, new Federal requirements are inexorably increasing our administrative costs and sometimes encroaching on traditional university autonomy. We presidents and chancellors were and are concerned that we lack the resources to fill in the financial gaps being created. Yet, we know we must meet these needs without Federal intrusion into our curricula courses, admission decisions and other aspects essential to the integrity of the academic enterprise.

The membership of the joint committee is broad, representing organizations which provide training for the overwhelming majority of health professions from the critically important allied health professions to the most sophisticated biomedical research activity.

We are convinced that, in discussing the training of health manpower, it is important to remember that we do not start with a clean slate. We have in place a decades-long Federal-university partnership. The education aspects of health professional schools have been expanded and strengthened with Federal support over the last 17 years. A certain mutual dependency has developed which, while not necessarily good, is a fact. Federal support started and has continued because of the recognition that these schools were national resources, that they were necessary for Federal goals, and that they were unusually expensive to operate. The partnership has been successful in creating a system that is the envy of the world. It has increased the total supply of health manpower of a high quality, improved access across economic and cultural barriers, and increased the training available for primary care physicians—to mention just a few accomplishments. Withdrawal of Federal support would result in cutbacks and deterioration in the quality of our training and/or higher costs to students with the resultant barriers to access.

We believe that the legislation now being developed is critical in the decade ahead.

Now Dr. Marston will speak specifically about issues raised by the bills at hand.

Dr. **Marston**. I am pleased to be back before this committee. I have fond memories of many years of testimony and work with the committee during the time I was at NIH, and you recall during those years health manpower was a part of my responsibility. We believe that we have been able to establish the reputation of American health education because we have had the fiscal flexibility to undertake activities to meet nationally perceived needs, to experiment with on new approaches and new programs.

We believe the Congress should avoid rigidly locking institutions into specific programs which would preclude stable, predictable, long-term support. We believe further that this Federal objective, as well as institutional objective, can be accomplished through a program of institutional support for health professions schools. Such a program would maintain quality; maintain enrollment capacity without requiring increases; maintain adequate facilities to conduct education programs; recognize the difference between the cost of education and reasonable tuition; provide incentive awards to institutions that initiate or continue special programs that meet federally determined objectives; and provide for schools meeting specific national objectives such as education of minority students or those who demonstrate exceptional financial need.

We believe the institutional support program should operate in a two-tier manner, a base grant providing subsistence level of institutional support at no less than the level received by institutions in fiscal year 1979. This will provide a commitment by the Federal Government to hold harmless institutions with respect to their previous acceptance of Federal mandates. The base grant would allow institutions to maintain teaching facilities in the basic and clinical sciences. It would provide stable funding, enabling institutions to adapt to changing national needs. It would help to insure maintenance of teaching equipment and instruments, library resources, and teaching laboratories, and, finally, it would help prevent tuition levels from becoming intolerably burdensome to students.

The second tier would provide particular support to institutions that undertake or continue programs in areas of national priority.

A stable health educational system capable of meeting national needs requires some form of basic institutional assistance on the Federal level. The costs of health education are unique because of the extraordinary degree to which it depends on clinical education. Whatever their ultimate earning power after many years of study, students cannot be expected to bear the entire burden of this extraordinary expense. Health professions education is performed for a national market, and the States cannot be expected to allocate much more of their own revenues for it. The medical schools themselves, as noted above, should not have to rely on faculty practice to make up the difference. A Federal role is necessary.

With these principles and the others noted in our prepared statement in mind, we applaud the Chairman and the ranking minority member of this committee for seeking to promote new legislation that in many ways addresses the principles delineated above.

With regard to S. 2375, we particularly commend separating the basic institutional support from institutional awards designed to support specific programs. We also agree that the concept of institutional support should be divorced from mandatory enrollment requirements.

Our greatest concerns lie with the proposals to decrease basic institutional support for schools if "undesirable characteristics" are in evidence. The negative scale of decreasing support opens the door to the same problems that trouble the capitation program. The absence of certain "desirable" may readily be translated into a "undesirable characteristic," and the formula for decreasing support simply becomes another way of imposing conditions on basic institutional support. We question the need for a negative scale of factors and believe that the goals that these incentives all could be achieved through positive incentives. We urge that you consider removing this feature from the legislation.

S. 2144 likewise is to be commended for recognizing the significance of basic institutional support in its special projects program and especially for recognition of the importance of research. However, it deeply concerns us to see this support wholly dependent on the acquisition of special project grants. Special project support has proven its capacity for supporting some part of health education programs in the national interest, but it does not pay for the total cost of such projects. Even a 20-percent bonus might not meet the total cost. As noted in our earlier discussion, special projects fail to provide the stable flexible support, they lack dependability, operate in an atmosphere of competition for a finite amount of funds, and do not respond to the fundamental problem of these institutions.

This brings us again to our theme of stability. Special project grants provide little or none to the programs they support. All too often, yesterday's special project is today's unfunded program. As long as institutions recognize the risk of launching special projects, there is nothing fundamentally wrong with the special project grant or the risks it carries. However, to seek to achieve stability through a most unstable vehicle pulls together disparate modes of funding that we believe will not achieve the purposes of this legislation.

There are some other questions we would raise at this point regarding specific elements of the proposed legislation. In S. 2375, the benchmarks for bonus points appear too high. It may be a case of the carrot being too far in front of the donkey's nose and could result in discouraging institutions rather than encouraging them to participate in programs of national consequence. Our first assessment suggests that even institutions making their best efforts and producing concrete and measurable results do not measure up to the benchmarks in the proposed legislation.

Several of our institutions have directed our attention to section 711 of existing law referred to in S. 2375. In their view, for private schools, "determination" of tuition is deadly. This provision on excessive tuition increases now in law is very vague and was intended for an entirely different purpose. In S. 2144 the tuition increase limit of 10 percent likewise strikes us as a serious problem. Members of the committee should understand that there are many powerful forces that work to keep tuition down at health education institutions. Institutions are not out to gouge the public or their students nor do they have the freedom to do so under any circumstances.

We suggest that both bonus point activity and special project grants and project support be directed at those parts of institutions that produce the results desired. For example, allied health programs are overwhelmingly undergraduate in enrollment. Students have access to the entire range of Federal student aid programs to help meet their costs. However, tuitions never meet the costs of operating these programs, which are unusually costly because of the needs for high technology in equipment and instruments, as well as increased faculty time and decreased student/faculty ratios. Without Federal support, allied health programs simply will not have resources to meet new and significant health needs of large segments of the population and to respond to the needs of students heretofore underserved by allied health education. Existing resources are not sufficient to accomplish these essential objectives. We commend S. 2144 for the support it offers the special projects for allied health.

We also commend S. 2144 for its support for renovating facilities, including research facilities.

Senator Schweiker, as I was writing this and reviewing your bill, I remembered the times that you visited us at NIH and the strong support you gave us in those years and since then, and I publicly acknowledge that and appreciate it at this time.

Turning to student financial assistance, we are university administrators, therefore, we have devoted much of this testimony to the question of institutional support. But we began and remain educators and our highest concern is the need for adequate financial assistance for students in health professions. We support a goal in Federal policy that would seek to insure that every qualified student, regardless of family income, have access to a health profession education. We would regret profoundly a return to an era when only children of well-to-do families made up the vast majority of students in medical schools and other health profession institutions.

In our experience the increased heterogeneity in health professions school classes has enriched the educational experience for all and is indubitably of benefit to society at large.

We are distressed at the rapidly increasing debt levels of our students. There is very little scholarship aid for health professions students, and most students who require financial aid depend on loans. Regrettably, student loan programs now are not structured for reasonable repayment of the large debts being incurred, particularly by medical and dental students. The repayment period seems too short and does not always take into consideration the limited ability of interns and residents to repay their debts. This could be remedied by creating longer and more flexible repayment schedules for student loans.

[illegible] greater concern, however, is the fact that students who are compelled by their financial circumstances to borrow large sums may find certain careers are closed to them, since they would not provide sufficient income to repay these large debts or to repay them quickly enough. Included among these careers would be precisely those which the Government wishes to encourage, such as primary care and research. A loan forgiveness program would be one way of easing the impact of high debt levels on career choice. The service contingent loan program in S. 2375 would provide a viable option for many students, particularly if national priority positions include a full range of practice beyond primary care and include such career options as teaching and research.

We note S. 2144 has an interest subsidy for the student involved in research training. This recognizes the problem of the burden of loan repayments which often precludes careers in research and academic pursuits. However, even after training, some careers might be precluded by the requirement to repay at the full interest rate.

Both S. 2144 and S. 2375 are worthy of commendation for their loan forgiveness sections for students who drop out of studies after the first year. We know that the uncertainties of what health professions education holds, coupled with high debt, would deter many excellent students from embarking on a health professions career unless they were provided with the assurance that, if it turned out to be an error, they would not be overwhelmed by a high debt. To extend this notion of forgiveness, we suggest that the broadest possible definition of research be included for purposes of payback for students who receive National Health Service Corps scholarships.

We have already noted our concern with the rising debt levels of our students because it precludes access for the poor and may distort postgraduate career choice. In addition, health manpower legislation might address the question of whether high debt levels will have an important effect on the cost of health care. We urge the subcommittee to consider some formal assessment of the long-term effects of student debt in all of these areas discussed.

We commend the sponsors of both bills for the excellent start in dealing with the problem of debt by providing some subsidy for students and some incentives to practice in areas of national need. We are pleased to note that the legislation includes research as well as primary care in the area of incentives. We are particularly gratified at the formal recognition of the importance to the nation of the clinical investigator as well as the fact that we face a meaningful shortfall in the numbers of trained M.D. researchers and health professional academics.

A suggestion regarding repayment—we believe that a student who borrowed $80,000 currently, at 15 percent, would have to pay back $1,120 per month for the 15-year payback period. Even were he able to get the loan at 7 percent, he would have to pay back $719 a month. We think S. 2375's concept of graduated repayments makes good sense in the context of the real capacity of health professionals to pay back loans shortly after they have begun their professional careers.

A final note on the National Health Service Corps. We expect to present shortly additional comments on the manner in which the corps has operated and how it can be made more effective. For now, may we note in behalf of several of our institutions their concern with the provision in S. 2375 that allocates 80 percent of the slots in the corps to State determined health shortage areas. For institutions like Georgetown University and George Washington University which, essentially, have no State, this provision could prove extremely harmful.

We thank the Chairman and the committee for the opportunity of presenting these preliminary comments. Our committee and their staffs continue to study the proposals in S. 2375 and S. 2144. We hope to confer very shortly with the members of your staffs on further comments and recommendations.

Thank you very much. We will be happy to answer any questions.

[The prepared statement of Dr. Danforth follows:]

AAU
NASULGC

Testimony before the
Senate
Subcommittee on Health and Scientific Research

March 12, 1980

by

Dr. William H. Danforth
Chancellor
Washington University
St. Louis, Missouri

and

Dr. Robert Q. Marston
President
University of Florida

Delivered in Behalf of the
AAU/ACE/NASULGC Joint Committee on Health Policy
in Association with AASCU

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Mr. Chairman and members of the Subcommittee, I am William H. Danforth, Chancellor of Washington University and Chairman of the AAU/ACE/NASULGC Joint Committee on Health Policy. I am accompanied today by Dr. Robert Q. Marston, President of the University of Florida, co-chairman of the Joint Committee. We are grateful to have the opportunity this morning to present to you our views on the most significant subject of federal legislation in the area of health manpower and, specifically, on the objectives and proposals contained in S. 2144 and S. 2375 sponsored separately by the Chairman and Ranking Minority Member of this Subcommittee. We are aware of Senator Javits' bill, S. 2378, but because of time limitations, have not had the opportunity to review this legislation. We request the opportunity to provide testimony for the record at a later date.

The remarks which follow must be viewed in the context of the organizations whose views we represent here today. For the past several years, we have co-chaired a committee made up of representatives of the Association of American Universities, the American Council on Education, and the National Association of State Universities and Land-Grant Colleges. The Committee includes university presidents, chancellors, vice presidents, deans, as well as health education specialists. Between them, these three organizations' memberships provide education for the overwhelming majority of health professionals, ranging from the most sophisticated post doctoral health research activity to the less complex but no less significant training in the various allied health professions. During the mid-1970's, as the federal government's support for health professions had increasing impacts on the stature and welfare of total higher education institutions, it became apparent to the executive heads--presidents and chancellors--of those institutions that the perspective and concern of the total institution was not adequately expressed in any organized manner. These executive heads of institutions of higher education formed the Committee in response to the growing call for direction, data, and guidance by members of Congress and their staff. The Joint Committee on Health Policy members restrict themselves to the agenda implied in the Committee's title--our concern is national policy in all facets of health, education, research, and delivery that involve the higher education institution; where the institution properly should play a role in meeting national objectives; and where the total institution is affected by national policy.

It is important to stress that the Joint Committee has sought not to present counter views to vice presidents for health centers or deans of medical, dental, public health, or other health professions institutions. In fact, representatives of the associations of deans and other officials in health education sit ex officio with the Joint Committee members and participate in discussion and in the development of our policy positions. Rather, it has been the continuing belief that only the executive heads of institutions could properly organize and present the viewpoints and positions on national policy issues that take into account the implications of a college and university in toto, and which, on certain occasions, can vary in important ways from the views of a single health professions department or college.

The university at its best is an integrated whole, with each of its parts enhancing and supporting the pursuit of knowledge and its dissemination through formal education and training. But no element within the university has so great an influence on its other programs and fiscal stability in contemporary times as do the health education segments. The training of health professionals calls upon the strengths of the institution in all of its sciences and in return determines greatly the quality of education and research at undergraduate level, graduate programs, and professional health professions training. Even in the broad parochialism of university administration, we see national health manpower policy decisions and programs as central to the well being of our institutions and their capacity to serve the constituencies in whose interests they have been created and are maintained both in the public and private sectors. Our special concerns with training and research in our institutions does not prevent us from understanding that national health manpower policy ultimately affects the entire health delivery system in the United States. We recognize the institutional role in sustaining and expanding the capacity of this nation to meet one of the fundamental obligations of a modern democracy: to provide its citizenry, which sees it as an absolute and universal right the access to high quality health care without regard to geography, economic class, race, or sex. We are mindful too at this time when the federal government seeks to successfully grapple with problems of inflation and other economic difficulties, that the cost of health care is at the core of objectives to gain control over inflation while at the same time not deprive those who are least capable of absorbing more of the burden of society. On that subject, we recognize that if the increasing costs of delivery of health care are not brought under control, the inevitable effect will be to reduce the available funds for training manpower and performing research--both absolutely indispensable in attaining our health goals for the nation and indeed humankind as a whole.

All of the above tells us that the legislation discussed before your subcommittee today is not merely another bill to reauthorize existing federal programs. The bills contain a quintessence of social programs for the nation with implications for all of the citizens. For our institutions, the implications are extraordinary. With the assistance of federal support, our health manpower training programs have become a truly excellent, having the capacity to produce adequate numbers of the most highly trained and skillful practitioners in all the health professions. At the same time, we are at a cross roads. The failure by the federal government to maintain its proper role in this partnership could result in a deterioration not only in quality in the training of health professionals, but also in access to such education. We are concerned that increasing student debt is discouraging some students from the pursuit of health professions education, while other health professions career choices are severely circumscribed by the high debt burdens. We emphasize that we are not starting to build a health manpower education system. Rather, this legislation seeks means of using an existing and accomplished system to meet higher goals while assuring that the institutions' academic and fiscal stability are maintained so that it can respond properly and access to this education is not limited to the privileged few.

In the past year, as we have worked to develop proposals for your consideration on health manpower legislation, we have sought to identify the special nature of our concerns. How may we maintain the integrity of institutions and their values that have led to the system of high quality education and extraordinary research productivity? During the last reauthorization, we discovered jointly with members of Congress that certain provisions of federal health education legislation inadvertently could erode the autonomy and necessary independence of higher education institutions. It is not merely a concern of the administrators of the institutions but of the nation as a whole that institutional integrity be preserved if what has been built over decades is not to be compromised. There are three factors that make the health related educational institution particularly vulnerable to manipulation and loss of autonomy. Health care problems frequently are surrounded by a sense of urgency. The federal government feels it imperative to act quickly, but the complexity and expense of operating within the modern health "industry" makes it simpler to turn to the educational system in hopes of effecting long-range changes at minimal cost. Second, the expanded missions and rapidly rising costs have placed many health education institutions in a position of dependency on the federal government not only for research funds but for flexible core operating money. Finally, because a significant portion of health science education is conducted in a teaching hospital patient care setting that involves the federal government as a prime payor, universities have still more dependency on government through these essential patient service programs.

In general, the federal-university partnership in biomedical research has worked well in assuring the federal government of mechanisms for achieving the goal of more knowledge in the biomedical sciences and at the same time generally preserving the integrity of the institution in which research is conducted. One central recognition in biomedical research was the inadequacy of project grants alone to achieve a maximum research productivity. A biomedical research support grant program that provides small but significant amounts of flexible funds to undergird the institutions' overall research problem represents a mechanism that deserves emulation in adapted form in federal health manpower programs. To protect what it has helped create, the federal government must assiduously avoid intruding in such areas as faculty hiring, retention and promotion; curricula decisions--what courses should or should not be taught, who will teach them, and how and when and where and what their content will be; admissions decisions and the requirements stipulated to determine that; examinations and the standards for promotion and graduation. (We recognize, of course, that employment and admission policies must be carried out under the federal guidelines for equity and affirmative action.) In writing new legislation for federal health manpower programs, this subcommittee and the Congress in general must exercise great care not to use the extraordinary power it now has as a result of the fiscal dependency of the institutions to disrupt health education programs or compromise institutional integrity in order to achieve an otherwise laudible goal.

We have not elaborated upon the quid pro quo inherent in the partnership as to the obligations and responsibilities of institutions because we believe that to be self evident. We see our position comparable to one of a fiduciary responsibility to the citizenry in the use of and accounting for federal dollars provided for health education and research programs. We believe that the federal agencies recognize the importance of institutional integrity and require of the institutions that they maintain their credibility by responsible administration of federally supported programs.

INSTITUTIONAL SUPPORT

We believe that we have been able to establish the reputation of American health education because we have had the fiscal flexibility to undertake activities to meet nationally perceived needs, to experiment with on new approaches and new programs. We believe the Congress should avoid rigidly locking institutions into specific programs which would preclude stable, predictable, long-term support. We believe further that this federal objective, as well as institutional objective, can be accomplished through a program of institutional support for health professions schools. Such a program would maintain quality; maintain enrollment capacity without requiring increases; maintain adequate facilities to conduct education programs; recognize the difference between the cost of education and reasonable tuition; provide incentive awards to institutions that initiate or continue special programs that meet federally determined objectives; and provide for schools meeting specific national objectives such as education of minority students or those who demonstrate exceptional financial need.

We believe the institutional support program should operate in a two-tier manner, a base grant providing subsistence level of institutional support at no less than the level received by institutions in FY '79. This will provide a commitment by the federal government to hold harmless institutions with respect to their previous acceptance of federal mandates. The base grant would allow institutions to maintain teaching facilities in the basic and clinical sciences. It would provide stable funding, enabling institutions to adapt to changing national needs. It would help to insure maintenance of teaching equipment and instruments, library resources, and teaching laboratories, and, finally, it would help prevent tuition levels from becoming intolerably burdensome to students.

The second tier would provide particular support to institutions that undertake or continue programs in areas of national priority. This form of support would recognize the importance of diversity in the programs of academic health institutions and would be based on broad categories of national need. Examples of programs supported include incentives to encourage recruitment of students previously disadvantaged groups; incentives to encourage students to enter careers in primary care; incentives to encourage institutions to serve as regional health education resources; and incentives to encourage students to enter careers in teaching and research.

Because we have so heavily emphasized "context," it seems appropriate to note in this section of our testimony the extradorinary attacks visited upon health professions institutions. All are struggling desperately to maintain financial integrity. They are disproportionately affected by inflation. Changes in Medicare regulations undermine reimbursement policies. Their endowments are being eroded as they are continuously tapped to enable them to maintain cost controls. In this atmosphere, the first to be discarded are new faculty and innovative programs, precisely that which must be developed today if we are to achieve the national goals that lie behind the legislation before your subcommittee. There is a growing dependency on expanded practice plans of teaching faculty within medical schools. This works as an emergency stop gap, but it already has served as a dangerous incursion on the teaching time and research commitments of this highely specialized faculty in our health professions institutions.

In our statement of principles above, we noted a point we would like now to emphasize: the infrastructure of health professions institutions must be undergirded and must be enhanced if the quality of education programs they offer is to be maintained. Like the rest of society, and the world of industry and business, health professions institutions must comply with new safety codes, new environmental regulations. Buildings must be reconstructed; facilities must be modified. Like the situation of industry, the institutions must now quickly respond to significant advances in instrumentation and equipment that have rendered so much of their teaching equipment obsolete. During recent years, federal policy makers have sought to refocus programs in health professions education in order to meet new national priorities. Generally, they have failed to take into account or at least admit to the concommitant imperatives that are involved in this "retooling." Institutions have developed in the past two decades in certain ways to meet federal priorities. They have tenured faculty and programs an place. To "retool" is an enormous task with comparable expenses. There is an accurate analogy to industry: "retooling" in a health professions institution is a major and radical enterprise that simply cannot be done in most instances within current fiscal constraints.

A stable health educational system capable of meeting national needs requires some form of basic institutional assistance on the federal level. The costs of health education are unique because of the extraordinary degree to which it depends on clinical education. Whatever their ultimate earning power after many years of study, students cannot be expected to bear the entire burden of this extraordinary expense. Health professions education is performed for a national market, and the states cannot be expected to allocate much more of their own revenues for it. The medical schools themselves as noted above should not have to rely on faculty practice to make up the difference. A federal role is necessary.

In addition to institutional support, a stable health education system also requires positive inducements and assistance to respond to specific health care problems. Posing conditions on basic institutional assistance will likely be ineffective and frequently will be intrusive. Some edicts from the federal government can impose costs without genuine compensation and without serving either national or institutional goals. Nevertheless, the federal government has an a right and at times an obligation to identify specific health care problems and promote answers to them through incentives.

With these principles and their arguments as background, we applaud the Chairman and Ranking Minority Member of this Committee for seeking to promote new legislation that in many ways addresses the principles delineated above. With regard to the S. 2375, we particularly commend separating the basic institutional support from institutional awards designed to support specific programs. We also agree that the concept of institutional support should be divorced from mandatory enrollment requirements.

It is frequently said that capitation has not met the need for more primary care practitioners in this country or that it has not solved the geographical maldistribution problem. The fact remains, however, that the number of family practice residencies has grown dramatically in this past decade. At the same time, many underserved states have been able to diminish their annual loss in physician numbers or even achieve positive gains. Such progress would not have been possible if it were not for the increased numbers of graduates available for the new family practice residencies and ready to serve in underserved areas. Numbers are not the total solution to our nation's special health care needs, of course, but the maintenance of an adequate manpower supply is the sine non qua of all available solutions. Congress can congratulate itself on the success of the capitation program. In its future manpower bill, it must maintain as well as build on that success in meeting specific health care needs.

We have some specific recommendations on ways in which S. 2375 might be improved. The proposal sets the base line support at approximately half of the FY '79 appropriations level. That level for capitation reflects a substantial erosion in institutional support that took place during the last several years. The proposed base line diminishes greatly the significance of institutional support. We recommend that a more reasonable base line figure be determined by the current authorization level.

If stability of health education is the principal goal of this support--and we believe it should be--then the authorizing legislation should seek to continue with minimal variation the degree of support institutions have been receiving. Using present student enrollment as a basis for allocation and basing figures on the percentage of current authorization figures could accomplish this. We heartily endorse the S. 2375 proposal that institutions serving special national needs receive bonus factors in the calculation of institutional support, and we especially applaud the principle that institutions presently meeting critical needs receive the same awards as those instituting new programs. However, we strongly recommend that bonuses be reserved for factors over which individual institutions have control. All factors should be rooted in school based, not student based, performance and should depend on data the schools can readily identify and supply.

Our greatest concerns lie with the proposals to decrease basic institutional support for schools if "undesirable characteristics" are in evidence. The negative scale of decreasing support opens the door to the same problems that trouble the capitation program. The absence of certain "desirable" characteristics may readily be translated into a "undesirable characteristic," and the formula for decreasing support simply becomes another way of imposing conditions on basic institutional support. We question the need for a negative scale of factors and believe that the goals that this incentives all could be achieved through positive incentives. We urge that you consider removing this feature from the legislation.

S. 2144 likewise is to be commended for recognizing the significance of basic institutional support in its special projects program and especially for recognition of the importance of research. However, it deeply concerns us to see this support wholly dependent on the acquisition of special project grants. Special project support has proven its capacity for supporting some part of health education programs in the national interest, but it does not pay for the total cost of such projects. Even a 20% bonus might not meet the total cost. As noted in our earlier discussion, special projects fail to provide the stable flexible support, they lack dependability, operate in an atmosphere of competition for a finite amount of funds, and do not respond to the fundamental problem of these institutions.

This brings us again to our theme of stability. Special project grants provide little or none to the programs they support. All too often, yesterday's special project is today's unfunded program. As long as institutions recognize the risk of launching special projects, there is nothing fundamentally wrong with the special project grant or the risks it carries. However, to seek to achieve stability through a most unstable vehicle pulls together disparate modes of funding that we believe will not achieve the purposes of this legislation.

There are some other questions we would raise at this point regarding specific elements of the proposed legislation. In S. 2375, the benchmarks for bonus points appear too high. It may be a case of the carrot being too far in front of the donkey's nose and could result in discouraging institutions rather than encouraging them to participate in programs of national consequence. Our first assessment suggests that even institutions making their best efforts and producing concrete and measurable results do not measure up to the benchmarks in the proposed legislation.

Several of our institutions have directed our attention to Section 711 of existing law referred to in S. 2375. In their view, for private schools, "determination" of tuition is deadly. This provision on excessive tuition increases now in law is very vague and was intended for an entirely different purpose. In S. 2144, the tuition increase limit of 10% likewise strikes us as a serious problem. Members of the

Committee should understand that there are many powerful forces that work to keep tuition down at health education institutions. Institutions are not out to gouge the public or their students nor do they have the freedom to do so under any circumstances.

We suggest that both bonus point activity and special project grants and project support be directed at those parts of institutions that produce the results desired. For example, allied health programs are overwhelmingly undergraduate in enrollment. Students have access to the entire range of federal student aid programs to help meet their costs. However, tuitions never meet the costs of operating these programs, which are unusually costly because of the needs for high technology in equipment and instruments, as well as increased faculty time and decreased student/faculty ratios. Without federal support, allied health programs simply will not have resources to meet new and significant health needs of large segments of the population and to respond to the needs of students heretofore underserved by allied health education. Existing resources are not sufficient to accomplish these essential objectives. We commend S. 2144 for the support it offers the special projects for allied health.

We also commend S. 2144 for its support for renovating facilities, including research facilities. This recognizes the interwoven nature of health research and health education. Institutions that train health professionals also train health researchers. Students in the health professions benefit enormously educationally from the research activity taking place around them.

STUDENT FINANCIAL ASSISTANCE

We are university administrators, therefore, we have devoted much of this testimony to the question of institutional support. But we began and remain educators and our highest concern is the need for adequate financial assistance for students in health professions. We support a goal in federal policy that would seek to insure that every qualified student regardless of family income have access to a health profession education. We would regret profoundly a return to an era when only children of well to do families made up the vast majority of student in medical schools and other health profession institutions. In our experience, the increased heterogeneity in health professions school classes has enriched the educational experience for all and is indubitably of benefit to society at large.

We are distressed at the rapidly increasing debt levels of our students. There is very little scholarship aid for health professions students, and most students who require financial aid depend on loans. Regrettably, student loan programs now are not structured for reasonable repayment of the large debts being incurred, particularly by medical and dental students. The repayment period seems too short and does not always take into consideration the limited ability of interns and residents to repay their debts. This could be remedied by creating longer and more flexible repayment schedules for student loans.

Of greater concern, however, is the fact that students who are compelled by their financial circumstances to borrow large sums may find certain careers are closed to them since they would not provide sufficient income to repay these large debts or to repay them quickly enough. Included among these careers would be precisely those which the government wishes to encourage, such as primary care and research. A loan forgiveness program would be one way of easing the impact of high debt levels on career choice. The service contingent loan program in S. 2375 would provide a viable option for many students, particularly if national priority positions include a full range of practice beyond primary care and include such career options as teaching and research.

We note S. 2144 has an interest subsidy for the student involved in research training. This recognizes the problem of the burden of loan repayments which often precludes careers in research and academic pursuits. However even after training, some careers might be precluded by the requirement to repay at the full interest rate.

Both S. 2144 and S. 2375 are worthy of commendation for their loan forgiveness sections for students who drop out of studies after the first year. We know that the uncertainties of what health professions education holds, coupled with high debt, would deter many excellent students from embarking on a health professions career unless they were provided with the assurance that, if it turned out to be an error, they would not be overwhelmed by a high debt. To extend this notion of forgiveness, we suggest that the broadest possible definition of research be included for purposes of payback for students who receive National Health Sevice Corps scholarships.

We have already noted our concern with the rising debt levels of our students because it precludes access for the poor and may distort post graduate career choice. In addition, health manpower legislation might address the question of whether high debt levels will have an important affect on the cost of health care. We urge the Subcommittee to consider some formal assessment of the long-term effects of student debt in all of these areas discussed.

We commend the sponsors of both bills for the excellent start in dealing with the problem of debt by providing some subsidy for students and some incentives to practice in areas of national need. We are pleased to note that the legislation includes research as well as primary care in the area of incentives. We are particularly gratified at the formal recognition of the importance to the nation of the clinical investigator as well as the fact that we face a meaningful short fall in the numbers of trained M.D. researchers and health professional academics.

A suggestion regarding repayment--we believe that a student who borrowed $80,000 currently, at 15%, would have to pay back $1120 per month for the 15-year payback period. Even were he able to get the loan at 7%, he would have to pay back $719 a month. We think S. 2375's concept of graduated repayments makes good sense in the context of the real capacity of health professionals to pay back loans shortly after they have begun their professional careers.

A final note on the National Health Service Corps. We expect to present shortly additional comments on the manner in which the Corps has operated and how it can be made more effective. For now, may we note in behalf of several of our institutions their concern with the provision in S. 2375 that allocates 80% of the slots in the Corps to state-determined health shortage areas. For institutions like Georgetown University and George Washington University which, essentially, have no state, this provision could prove extremely harmful.

We thank the Chairman and the Committee for the opportunity of presenting these preliminary comments. Our Committee and their staffs continue to study the proposals in S. 2375 and S. 2144. We hope to confer very shortly with the members of your staffs on further comments and recommendations. Thank you very much. We will be happy to answer any questions.

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University Hospitals of Cleveland

Attachment - Dr. Danforth testimony

March 13, 1980

The Honorable Richard S. Schweiker
United States Senate
253 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Schweiker:

Dr. Bob Marston and I appreciated the opportunity of speaking at the hearings on health manpower Wednesday.

I appreciate your concern and interest in the subject and also your understanding of it.

Senator Metzenbaum asked about physicians doing more to help fund medical schools at a time when the federal government is striving valiantly to balance the budget. There was insufficient time to answer the question, but you might be interested in the role of physicians at Washington University in the funding of medical education.

1) The full-time salaried physicians are engaged in clinical practice in excess of that required for academic reasons. The money so earned goes to the School of Medicine to underwrite our costs. In the last seven years income from this source has increased fourfold. It accounts for 22 percent of the income of the School of Medicine, up from 14 percent seven years ago. This figure excludes the Department of Radiology which is separately budgeted. (During this period the percentage of the total income of the Medical School coming in federal grants and contracts has declined from 54 percent to 36 percent.) These physicians are, in fact, doing their share to fund the School of Medicine. From my standpoint they are of necessity doing too much so that less time and energy are available for teaching and research.

2) Approximately 690 physicians in private practice give time on a voluntary basis, totally free of charge, to the teaching and service programs of our medical center.

3) Last year 1,670 of our physician alumni made contributions to Washington University Medical School totalling $330,913.

Again, thank you for your interest and your constructive ideas.

With best regards,

Yours sincerely,

William H. Danforth
Chancellor

COPY

b.c. Robert Blackburn
Samuel B. Guze
Robert Knouss
Jerry Roschwalb
Carol Scheman
Virginia Weldon

Senator **Metzenbaum**. Thank you, Dr. Danforth and Dr. Marston.

Let me ask a couple of questions. I recognize that university presidents somehow believe that health profession schools are important and valued components of the university community. But I also understand that a common nightmare of university presidents is that they will wake up one morning and find that their institutions have a new health professions school.

Why is this such a nightmare for universities in these days and times?

Dr. **Danforth**. Senator, I might start out by just talking about medical school at Washington University, why it is a nightmare.

We are proud of it. Since the school of medicine brings in 60 percent of the operating revenues of Washington University and accounts for 60 percent of the expenditures, any threat to its financial stability is a serious threat to the entire institution. Significant losses cannot be made up from other institutional funds. The school is funded from multiple sources, many of which appear to be unstable at this time. Federal support is, for example, a problem for us. It is declining as a percentage of the total expenditures.

In 1972, 54 percent of the medical school income came through the Federal Government. In 1979, that has fallen to 36 percent. (While this is going on, there is a great deal more Federal control.) To make up these losses of funds our faculty have increased clinical practice to earn money. This activity takes them away from their academic pursuits; however, it is necessary because we do not have the resources to underwrite these gaps that occur.

When you think that 60 percent of our total income is already going to medicine, you can see we do not have much flexibility to add more.

Senator **Metzenbaum**. Dr. Danforth, that being the case, knowing the limitations of the Federal budget difficulty of raising private funds, have the university presidents ever given any consideration to some program—we know about the repayment of the loan program—but some program where the medical profession itself accepts a special kind of responsibility for the medical schools of this country?

Dr. **Danforth**. I think, Mr. Chairman, that we have very good relations with the agencies that represent physicians, but to think of the medical profession itself underwriting health education, I think is to probably expect that there is more organization to the medical profession and more ways of influencing it than actually there are.

Senator **Metzenbaum**. Maybe we need a windfall profits tax.

Dr. **Danforth**. Well, I do understand your concern here. I note that physicians pay—or most pay—very high income taxes, which helps a bit.

Senator **Metzenbaum**. I am always concerned about—well, we have problems that need funding, and we always turn as a place of last resort to the Federal Government. Yet the hue and cry throughout the Nation is to balance the budget. I sometimes say to myself, "Where is it going to come from?" Problems are there; the solutions are not simple; and while I say it facetiously about raising the issue with the medical profession, and yet somehow we have to find some innovative thinking, some new ideas. You say that 60 percent of your total budget goes for medical school. We just cannot find the Federal trough adequate to keep pouring out more and more billions. Somewhere we have got to have some new ideas and some new concepts. I think it is imperative that the profession itself, the schools, the doctors, the Government, perhaps, and people in the industry become involved in this issue because it is becoming an intolerable situation and we are not coming up with answers.

The question is, how much will the Federal Government put into the package. I think there is a resentment on the part of the American public as to our whole budgetary process here.

Dr. **Marston.** I sympathize with the concerns you have expressed. I have looked on health in this Nation for the last one or two decades as playing an additional role of looking at some of the basic processes of our democracy and how we think about it.

I think one of the ways—a suggestion that a surtax would work, is that it would be very likely passed on again to the patients and to the public; and I would suggest that eventually what you are talking about is, is their way to get payment for the practice of medicine, whether it be by third-party payments or others, for an appropriate part of the educational process which serves those needs.

I believe that we still leave a gap.

In really adding to what Dr. Danforth has said, I believe these two bills speak to the gap areas, institutional support area, institute and assistance area, and they would go a long way toward helping to stabilize the unstable situation in our Nation's health centers today.

Senator **Metzenbaum.** One more question.

University presidents are in a unique position to increase representation of minorities in the health professions, in both baccalaureate programs as well as health profession schools.

How can these resources be activated to solve the problem of access to health professions & education for our disadvantaged population?

Dr. **Danforth.** Mr. Chairman, I think, A, of course considerable strides have been made, and I think everyone within our medical schools are symphathetic toward that goal. I do note in the bill proposed by Senator Kennedy that there is a special section with separate authorization to encourage medical schools to work not just by themselves, because they really cannot determine the total applicant pool by themselves, but with colleges and other education agencies to increase the pool of minority applicants applying to medical schools. I think that sort of thing is a good step forward.

Senator **Metzenbaum.** Thank you.

Senator Schweiker?

Senator **Schweiker.** Thank you, Mr. Chairman.

First I would like to welcome both Dr. Danforth and Dr. Marston. I think we are very fortunate to have two of the most distinguished educators in the country here today participating with us in trying to chart a policy in health manpower. I have had occasion to work with both in the past.

As Doctor Marston indicated, my first assignment as a new member of the Health Committee some years back was to go and get indoctrinated by you, Doctor Marston, and you did a very good job of informing me about NIH and what was going on there.

I might say you did a fine job in administering that agency, and I appreciate that.

In my bill, S. 2144, my student assistance program contains partial interest subsidies for medical students. Actually, it pays for subsidies over the 7 percent interest rate. When we drafted the bill, that did not seem like but a half a loaf, but when we talk about the current 18 and 20 percent interest, it becomes a significant contribution to a student's loan to make subsidies available. These subsidies would obviously vary, and that way, the student would not be affected by the fluctuations in the prime rate. He, or she, could know as they went through his or her college career that they would have a fixed target that they would have to meet and not be subject to what the prime was doing, plus a few points.

In addition, my bill would continue this interest subsidy for up to 8 years if a doctor pursues research training and a research career. I think this is a very significant incentive to get people into research which I know is one of your concerns.

My question is, Do you think this does address the needs of health professionals in terms of our young students who wish to be researchers. Also what else might you suggest?

Dr. **Marston**. We very much commend you for including research training.

As you know, one of the major problems now is in that particular area, and I think the only question, Senator, is the one you raise yourself, is how much is enough to do the job with a group of students, especially those who come from less affluent families, to assume great debts prior to the time they finish, and finish the additional training they have.

But the interest subsidy, yes, the inclusion of research training, yes, and I think the only question is whether that is enough to serve all the needs.

Senator **Schweiker**. I just sat through—in fact, I chaired a hearing yesterday in the Appropriations Committee which basically got into the matter of research training grants.

Dr. Marston, this is right up your alley.

Last year, the administration, rather arbitrarily, just about wiped out all training grants and used the money for other research purposes. This raised a conflict with the Senate position in conference and on the bill, because we thought it was very strongly needed.

This year, the administration is also cutting back training grants significantly. I guess my question to you is, how important is some support for trainees or researchers in this area, and what is the problem of retaining people in this area?

Dr. **Marston**. A number of problems. The one we see most dramatically is the decrease in number of clinical investigators; high cost, low income, absence of the training grant support in adequate amounts, and we have seen a precipitous decline in the number of individuals entering research who are M.D.'s, and who are absolutely essential in providing the type of information, the type of research that is needed by this Nation.

I know that has been brought to the attention of this committee and in the Appropriations Committee, too.

Dr. **Danforth**. We are really very grateful for your interest in this area. It is the hope of the future, holding down our health care costs.

Senator **Schweiker**. One other question.

My bill modifies existing construction grant programs to emphasize interest subsidies for modernization and innovation of teaching and research facilities.

I wonder if either of you have a position on this feature, or any comments on it?

Dr. **Danforth**. Senator, we are of course very pleased at the interest subsidy. This is a problem. Our facilities, many of them, are aging and continue to age. We also believe that it would be of course very helpful for some schools that have particular needs to be able to apply for grants as well.

Senator **Schweiker**. Thank you.

Senator **Metzanbaum**. Thank you very much, Dr. Danforth and Dr. Marston.

Dr. **Marston**. Thank you.

Dr. **Danforth**. Thank you.

Senator **Metzenbaum**. The Chair wishes to admit publicly his own embarassment about having to rule rather firmly on the time commitments of Senator Schweiker and myself and to limit the very prominent persons who have come here from all over the United States to have input on this legislation. We want them to do so, however I must confess to you I do not know of any alternative except to provide a rule with a rather strict hand on the question of timing. Absent that, a certain number of witnesses at the end of the morning will not be able to be heard, and every witness is as important as each other witness. I apologize if I am rather strict on time, but I do not know of any other choice that would enable me to conduct this hearing.

Your entire written statements will be included in the record and will be considered by the committee in its deliberations.

Our next panel consists of Michael K. Gemmell, executive director, Association of Schools of Public Health; Gary Filerman, Ph. D., president, Association of University Programs in Health Administration; and Lee Holder, Ph. D., dean, College of Community & Allied Health Professions, University of Tennessee, representing the American Society of Allied Health Professions.

STATEMENTS OF MICHAEL K. GEMMELL, EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; GARY FILERMAN, PH. D., PRESIDENT, ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION; AND LEE HOLDER, PH. D., PRESIDENT, AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

Mr. **Gemmell**. Mr. Chairman, I am representing the Association of Schools of Public Health. The deans of the U.S. schools of public health look forward to working with you and members of your staff in developing a bill that seeks to:

First, provide an adequate supply of health personnel to work in areas of national need such as disease prevention, health promotion, health administration, environmental and occupational health, epidemiology, biostatistics, nutrition, among others;

Second, increase the supply of public health students and graduates from underrepresented minority groups;

Third, implement the goals outlined in the Surgeon General's Report, "Healthy People";

Fourth, support programs training medical personnel in areas of preventive medicine and dentistry;

Fifth, upgrade the management skills of executives in health policy and management programs; and

Sixth, provide institutional support to schools of public health to enable the training of public health specialists in manpower shortage areas.

We believe, Mr. Chairman, that S. 2375 addresses these points, especially the last one. The bill provides basic financial institutional support for costs incurred by the schools of public health in providing comprehensive training of personnel charged with the responsibility for carrying out federally initiated programs and national health goals outlined in "Healthy People."

Mr. Chairman, the schools of public health are in the business of training men and women for public service. Our graduates work primarily in the public sector in areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, State, and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others.

The bills before us target financial support to categorical programs that are responsive to national health requirements. The quid pro quo implied in Federal support is based on results in terms of increased minority enrollments, public service commitment of students and graduates attracted to specialty and geographic areas in need. Federal support insures the training of professionals who would provide services in disease control, protection against health hazards, health services management, cost containment, health promotion as well as disease prevention.

Mr. Chairman, we also support certain provisions in S. 2144; the bill offers new and innovative approaches to health professions student assistance programs. Although S. 2144 does not propose to continue capitation, it does propose to authorize needed increases in traineeships for public health students and special projects grants to schools of public health. It insures the production of personnel in needed public health priority areas.

ASPH also supports in general S. 2378. It provides assistance to health administration and students that will eventually work in federally supported health facilities and programs.

We join our colleagues in the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine in supporting provisions in S. 2375 and S. 2144 that provide support to academic programs and residencies in preventive medicine. If a change is to be effected in our health care system to bring about a greater emphasis on prevention, a change must be made in the attitudes and behavior of the medical profession.

In closing, Mr. Chairman, we must make one final point:

The schools of public health are heavily dependent upon Federal assistance to increase the capacity of the schools to respond to emerging national, State and local public health needs and also to enable them to offer comprehensive graduate training in critical areas which are unsupported by other funding sources, including State government and parent universities.

The deans thank you for giving us time to present our views. We request that our detailed statement describing further goals and objectives of the schools of public health and our specific comments on S. 2375, S. 2144, S. 2378, and the administration's proposal, be incorporated into the record of today's hearing.

Thank you.

[The prepared statement of the Association of Schools of Public Health, represented by Mr. Gemmell, follows:]

Association of Schools of Public Health
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[illegible]

STATEMENT

OF

THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

BEFORE

THE LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

ON

EXTENSION AND REVISION
OF
P.L. 94-484

THE HEALTH PROFESSIONS
EDUCATIONAL ASSISTANCE ACT

Washington, D.C.
March 12, 1980

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STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC AFFAIRS OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON BILLS (S. 2375 AND S. 2144) TO EXTEND AND REVISE P.L. 94-484, THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT, MARCH 12, 1980, WASHINGTON, D.C.

The Association of Schools of Public Health (ASPH)*, which represents all of the twenty-one U.S. Schools of Public Health, appreciates this opportunity to present its views on S. 2375, the "Health Professions Training and Distribution Act of 1980," S. 2144, the "Health Professions Educational Assistance and Nurse Training Act of 1980" and the Administration's health manpower proposal. S. 2375 and S. 2144 are comprehensive legislative proposals which seek to accomplish a number of very important goals.

The purpose of this statement is two-fold: one is to make the Congress and this Subcommittee aware of the major training and financial problems facing Schools of Public Health today; and two is to clearly spell out the ASPH position on the federal role in public health professional educational assistance programs.

Mr. Chairman, public health deals with the protection and improvement of community health by organized community effort. Public health activities are essentially a public or government responsibility. The services of public health agencies are not reimbursable on a fee-for-service basis as are personal health services. Rather than treating the symptoms of disease in one person, public health is concerned with discovering how a disease occurs, in halting its spread and in organizing programs for those who have been or may be affected by it in a community, a state or a nation. The goal in theory and in practice is to discover the source of ill health and to reduce or eliminate it at the earliest point. As a public responsibility such preventive activities have been largely supported by public funds.

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*ASPH is the only national organization representing the Deans, faculty and students of the twenty-one Schools of Public Health. The Schools represent the primary educational system that trains personnel needed to operate our Nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

Public health measures have been successful in controlling communicable diseases as a major cause of death in the United States. While these measures should continue to prevent a resurgence, today the major public health problems in this country involve the causes and control of chronic diseases such as cancer and heart disease; the control or elimination of environmental health hazards; and the provision of equal access to quality health care at reasonable costs.

In recent years Congress has addressed these problems through significant legislation dealing with environmental health, disease prevention and planning, evaluation and management of the health care delivery system. Such legislation has created growing manpower needs in public health. The demand is expected to continue and increase as new programs to improve the quality of life and reduce health care costs are enacted.

Few studies have been conducted on the impact of the new legislative initiatives on the demand for public health manpower. A study conducted in 1973, prior to the enactment of the health planning law and the current emphasis on cost containment, showed a short fall in every category of professional public health manpower:

U.S. Estimated Supply of and Requirements for Selected Categories of Professional Public Health Manpower*

	Professionals with masters level training or higher-			
		1980 Supply, assuming		
Occupational Category	Base Year Supply (1970 unless specified)	Constant School Output	Reduced School Output	Possible 1980 Requirements
Environmental Health	2,200	4,300	3,800	5,000
Epidemiology	1,000	1,800	1,500	2,000
Health Education	2,000	3,600	3,100	6,000
Health Services Administration	8,500	18,200	15,300	25,200
Health Statistics	1,100	1,700	1,500	2,500
Maternal Health, Family Planning & Child Health	800	1,800	1,500	2,000
Mental Health	200	400	350	1,100
Public Health Dentistry	300	550	500	550
Public Health Nursing	2,457	5,200	4,500	5,700
Public Health Nutrition	1,000	1,800	1,500	2,600
Public Health Veterinary Medicine	200	350	300	550

*Department of Health Administration, School of Public Health, University of North Carolina. Professional Health Manpower for Community Health Programs. Chapel Hill, North Carolina, 1973.

The Schools of Public Health are the major manpower training resource available to meet the increasing demand for highly trained and competent personnel in the public health field.

Federal health professional manpower policy has focused almost exclusively on physicians and has based policy decisions affecting other health professions on conclusions relating to physicians. For example, studies have shown that there may be a substantial oversupply of physicians around 1990. Based on this finding the President's FY 1981 budget request assumes an oversupply of all health professionals and consequently targets its request for health professions education programs at minimizing the future oversupply of health professionals. As suggested by the chart, the available evidence indicates an undersupply of public heatlh personnel. Also the recent Surgeon General's report (*Healthy People*) found that there is a need for prevention manpower especially in the fields of epidemiology, biostatistics, health administration, environmental health, occupational safety and health, nutrition, among others. Further, a December 1979 HEW report to Congress on community and public health personnel also called for increased federal support to programs training professionals in these priority public health areas.

The Schools of Public Health* have been educating professionals in the techniques of public health practice, health preservation, health promotion and disease prevention and control since the first decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. Today there are twenty-one fully accredited Schools of Public Health in the United States, 7 at private and 14 at public universities.

Schools of Public Health are distinct from other health professions schools in a number of ways. They are oriented to the community and prevention rather than to the individual and cure. They train people in a value system that is equalitarian and public service oriented. They train persons to be need oriented rather than demand oriented. They teach techniques of need response and how to view the "community as a patient". Students are prepared for community teamwork and administration rather than private practice. To solve community health problems the typical graduate works on a team in organized community action, deals with administrative problems and must understand group behavior as well as health care techniques.

Located in 17 states and Puerto Rico, the 21 accredited Schools of Public Health train students from every state in the nation. The Schools have a combined enrollment of over 7,000 students and a faculty in excess of 1,700.** Graduate education in the 21 Schools is organized around a number of major specialties.

*University of Alabama in Birmingham, University of California-Berkeley, University of California-Los Angeles, Columbia University, Harvard University, University of Hawaii, University of Illinois, The Johns Hopkins University, University of Loma Linda, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, University of South Carolina, University of Texas at Houston, Tulane University, University of Washington and Yale University. Boston University and San Diego State University will be seeking accreditation in the Fall of 1980.

**When federal support for Schools of Public Health began in the late 1950s, 11 Schools were training 2,000 students. Federal support has remained constant since the early 1970s.

Some of the fields of concentration offered by the Schools are:

Behavioral and Social Sciences
Biostatistics
Environmental Health Sciences
Epidemiology
Health Services Administration,
 Policy & Management
Health Education
International Health
Maternal & Child Health
Nutrition
Occupational Health & Safety
Population Studies
Public Health Practice & Program
 Management (e.g., public health nursing)

Graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, state and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 45 percent of graduates in a single given year go into federal, state or local government service, 34 percent work for either non-profit community health agencies or universities and 4 percent work for industry.

ASPH data shows that the Schools no longer primarily train professionals for state and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the Schools have made major efforts to train stduents in health administration and environmental health, now the two most frequently chosen areas of specialization. Health administration attracted 1,069 students in 1977-78, or 16.6 percent of the total. With health planning and policy studies counted in, that total would be even higher. Hospital administration, treated as a separate discipline, drew an additional 299 students (4.6 percent) in 1977-78. With biomedical laboratory sciences reported separately, environmental health narrowly displaced epidemiology as the second most frequently chosen specialty. Biostatistics ranked third with 440 students in 1977-78 (6.8 percent), while health education was fourth with 421 students (6.5 percent) and nutrition fifth with 382 students (5.9 percent).

Students who attend the Schools are often mid-career professionals with a prior commitment to public service. The average age is slightly over 30. A large percentage are part-time students already working in the public sector while upgrading their skills. It should be noted that a public health degree does not increase the income potential of the graduate as much as other health professions degrees. Schools of Public Health are in the business of training men and women for public service.

The 21 accredited Schools are two-thirds state owned and one-third privately owned. In FY 1974, less than one percent (0.9) of total state expenditures for support of health manpower training institutions went to public health.* The lion's share (64.5 percent) went to the training of phsyicians. None of the private institutions, except the University of Pittsburgh, receives state support. Private Schools by and large depend on the traditional means of support such as endowments, tuition gifts, etc., yet they are in the business of training workers for the public sector.

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*The Congressional Research Service is presently conducting a study to determine 1979 levels of state support to Schools of Public Health.

FEDERAL ASSISTANCE TO SCHOOLS OF PUBLIC HEALTH

I. Institutional Support

Federal assistance to encourage development of experienced public health professionals began with traineeship support in 1956, thus making federal aid to Schools of Public Health one of the oldest health manpower training programs. Federal institutional support was authorized in 1958 and the special project grants program began in 1960. Since the Federal assistance program began, the number of accredited Schools has almost doubled from 11 to 21 and the enrollment has increased fivefold.

The basic intention of Federal institutional support to public health schools is to increase the supply of health manpower in fields where the demand is high and/or where a shortage exists. The July 1979 Surgeon General's Report said that although there is a lack of public health manpower data,* there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health service administrators. The overwhelming majority of these professionals are trained in Schools of Public Health.

Institutional support to both public and private non-profit Schools has provided a general subsidy which may be used for any educational program of the Schools including teaching and community service. Such grants supplement other sources of income and permit a degree of flexibility in program development. For the newer and smaller Schools the institutional subsidy has stimulated growth and provides a measure of financial stability.

Providing basic institutional support is a means whereby the Federal government can share the costs** with states and private institutions for the training of public health personnel to manage and operate governmental health programs.

The Schools still need flexible but accountable funds which they can use to support parts of their overall program which have been weakened by insufficient Federal, state and local and private financing.

Adequate training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment. However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide adequate support for curriculum development and program support.

ASPH believes that S. 2375 would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools to provide health promotion and disease prevention activities in the community.

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*Reasons for the lack of data are several, such as lack of uniform and fixed definitions and requirements for employment, methodological problems and high costs of gathering information.

**Teaching costs per student per year approximate those of medical schools. ASPH estimates that it costs $10,000 to train one public health student each year.

An alternative to capitation is needed because of the general disfavor of the program. While it has been effective in increasing enrollment, it has not been effective as a means of addressing the problems of specialty and geographic maldistribution. Dealing with these problems requires targeted programs of assistance. Basic institutional support would assure the health care system an adequate supply of public health professionals in defined national priority areas. S. 2375 targets financial support to categorical programs that are responsive to national health requirements and programs. The quid pro quo implied in Federal support is based on results in terms of increased minority enrollments, public service commitment of students and graduates attracted to specialty and geographic areas in need. Federal support, in terms of instituitonal, student, and curriculum assistance, challenges Schools to place emphasis on Federally defined priority areas. It ensures the training of professionals (such as health administrators, biostatisticians, epidemiologists, public health nurses, preventive medicine specialists, environmental and occupational health specialists, nutritionists, maternal and child health workers, among others) who would provide services in disease control, protection against health hazards, health services management, cost containment, health promotion as well as disease prevention.

The Administration has proposed the termination of capitation funds for all health professions schools in FY 1981 based on the assumption that capitation grants are incentive payments to Schools to increase their enrollment and are no longer needed since there is or will be an adequate supply of licensed health professionals in the 1980s and 1990s. Yet ASPH studies and two prepared by HEW* point out that the demand for the types of health manpower trained by Schools of Public Health will increase as a result of current and future legislative and Administration initiatives in the fields of disease prevention and health promotion (not to mention cost containment and improved management of health services delivery). These initiatives are looked upon as means to improve the quality of life and to reduce skyrocketing health care costs.

In view of the growing demand for health manpower stimulated by recent passage of Federal programs such as health planning, clean air, clean water, toxic substances, health maintenance organizations, older Americans act, nutrition programs, PSROs, and other federal initiatives such as cost containment, child immunizations, mental health, child health, health promotion, rural and urban health initiatives, among others, the ASPH believes that continued institutional support is justified by the nature of public health as a governmental enterprise aimed at the improvement of the public's health. Furthermore, the Schools of Public Health presently represent the major source of supply of trained personnel to implement and manage the Federal health programs and initiatives. Institutional support is simply a partial reimbursement of costs incurred by the Schools in providing comprehensive training of personnel for Federal, state and local governments, industry and voluntary health agencies charged with the responsibility of carrying out federal programs and meeting Federal health requirements.

In terms of actual percentage that institutional support would represent as part of the federal health budget, the figure ($9 million) is miniscule. When one examines the percentage these grants will represent in the total operating funds of

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*A December 1979 report to Congress on Community and Public Health Personnel and the Surgeon General's Report, Healthy People.

Schools of Public Health, however, the percentage will be around 10 percent.

The Federal funds received by Schools of Public Health have been considered to be the Federal government's share of preparing public health personnel to meet the needs of public today and for the future. The amounts, while small in comparison to overall expenditures, have and will continue to contribute to the preparation of this vital health resource.

The capacity of the Schools to respond to emerging needs, to offer a balanced curriculum and to provide graduate training in critical areas which are unsupported by other funding sources would be severely reduced by the absence of institutional support. To delete institutional support now or in the near future will diminish the ability of the Schools to serve the Nation's health in the manner intended by those national leaders who first conceived the notion of financial support to Schools of Public Health.

We support Section 771(j)(1) of S. 2375 because it provides stable support to the public health graduate educational institutions. Financial support in the bill is targeted to categorical programs and goals that are complementary to national requirements and public health needs. The quid pro quo implied in Federal support would be based on results:

- -- Increased percentage of minority students enrolled
- -- Increased public service commitment of students and graduates working in areas of national need.*

Federal support, then, is based on a sliding scale or an incentive approach. The more a School moves in the direction of national priority areas, the more Federal support it would receive.

The justification for continuing institutional support to students and Schools of Public Health is generally the same as it was 20 years ago when the program first began. Public health schools train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH strongly urges the Committee to enact Section 771(j)(1) of S. 2375.

II. Student Assistance

The ASPH strongly urges the enactment of Section 107 of S. 2375 and Section 747(b) of S. 2144. Both bills provide the needed support to students entering or continuing their professional careers in public health. Both bills amend Section 748 of P.L. 94-484.

When the "Health Professions Educational Assistance Act of 1976" was originally passed, Section 748 authorized traineeships for Schools of Public Health alone. Subsequently, it was discovered that preventive medicine and dentistry residencies had been overlooked in drafting the Act. This section was then amended to cover them and to include other public or non-profit institutions providing graduate training in public health. The authorization level was raised $1 million for each of the years of authorization to accommodate the expanded eligibility.

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*Epidemiology, biostatistics, health administration, environmental and occupational health, nutrition, among others.

The present traineeship authority requires that a specified percentage of these awards shall go to students with a post-baccalaureate degree or with three years work experience in health services and who are pursuing a course of study in designated areas of specialization. To implement this provision Schools must stress recruitment of older students with prior work experience or other professional degrees and discourage recruitment of recent college graduates. This provision was based on the mistaken notion that Schools of Public Health should only train senior level administrators and policy makers (i.e. the leadership cadre) rather than operational level personnel. This provision is deleted in S. 2375 and S. 2144. ASPH vigorously supports the new language.

The traineeship program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, an entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, particuarly minorities, to afford graduate education in public health schools. Furthermore, many undertake graduate study in public health at mid-career and have important family obligations. Others have already accrued heavy debts from their previous education. Over 50 percent of students received some form of financial help in 1978-79.

The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Over 90 percent of the graduates are employed by governmental and community agencies and universities. Their modest salary levels are reflected in a recent survey which showed an average of only $30,000 after 15 years of experience.

Calculated in constant dollars, traineeship support has declined by 48.6 percent since 1970 with enrollments growing in that same period (52 percent) this has meant less money to be spread among more students. ASPH supports increased authorizations for S. 2375 and S. 2144.

It should be noted that the limitation on the amount of an individual traineeship award puts the Schools of Public Health at a competitive disadvantage in recruiting physician students in residency programs. In revising P.L. 94-484, ASPH urges Congress to provide the same latitude on the amount of traineeship funds allocated to physicians in clinical residency programs in medical schools.

III. Special Projects

ASPH supports the special projects grant sections of S. 2375 (Section 799) and S. 2144 (Section 747). The latter goes further in greatly re-gaining the losses to the Schools brought on by inflation. As inflation has gone up, Federal assistance in special project grants has gone down. In FY 1973, the Congress appropriated $6 million for special projects; in FY 1980 it approved $5 million which represents $3.3 million in 1972 dollars. Yet School enrollment increased 40 percent since 1973.

As in the institutional support provision of S. 2375, Section 799 of S. 2375 and Section 747(a) of S. 2144 target funds for projects designed to place emphasis on curriculum in the areas of national manpower needs. The grants are earmarked to federal initiatives that are stimulating a growing demand for public health personnel.

The special project grants program began in 1960 and was intended to aid accredited Schools of Public Health to develop new programs and expand existing programs in biostatistics and epidemiology, health administration, health planning, health policy analysis and planning, environmental and occupational health and dietetics and nutrition. An amendment by the 95th Congress opened this authority to any educational entity offering programs in the above areas without increasing the authorization level.

Project grants provide support for the development of training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include the training of leadership for management and specialized responsibilities in new and projected health agencies such as HMOs, PSROs, HSAs and agencies to control environmental health hazards.

Project grant appropriations have been decreasing since 1973. Inflationary pressures have accelerated that decline. Calculated in constant dollars in the FY 1980 appropriation of $5 million is 40 percent less than the amount appropriated in FY 1973.

Further, Schools of Public Health do not receive all of the money appropriated. As a competitive program, Schools of Public Health must now compete with all programs in health administration, environmental health, nutrition and other educational entities offering training in the specified fields. However, we support Federal assistance to these programs since they greatly contribute to the needed public health manpower pool.

ASPH joins the Association of University Programs in Health Administration in supporting the increased authorization levels in S. 2375 and S. 2144 for special project grants to Schools of Public Health and graduate programs in health administration. Here is the justification. Training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment. However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide support for curriculum development and program support. ASPH believes that increases for special project grants would provide the basic generic support for improving the quality of the curriculum and teaching technqiues and enhance the capacity of the Schools and health administration programs to provide health promotion and disease prevention as well as health services management activities in the community, state and nation.

IV. Preventive Medicine,Dentistry and Public Health Residencies

ASPH supports Section 793 in S. 2375 and Section 738 in S. 2144 that provide support to residencies in public health, preventive medicine and dentistry. Healthy People underlined the need to increase the supply of professionals in these special practice areas. Also a recent Institute of Medicine report, "A Manpower Policy for Primary Health Care," made a number of recommendations including one to increase the number of residency positions in preventive medicine.

ASPH concurs with its sister organizations, the American College of Preventive Medicine and the American Teachers of Preventive Medicine, in their efforts to have Congress recognize the special needs of programs in preventive medicine. They maintain that if a change is to be effected in the health care system to bring about a greater emphasis on prevention, a change must be made in the attitudes and behavior of the medical profession. Medical students, and hence physicians, are not trained to understand the potential of prevention. To promote an awareness of prevention within the medical profession, it is necessary to foster integration of prevention principles within federal policy regarding health manpower training. These organizations (including ASPH) are pleased that S. 2144 and S. 2375 both attempt to accomplish this by providing incentives for medical schools to integrate prevention within their curriculum and by providing direct support for departments of preventive medicine and residency training to students in preventive medicine in Schools of Public Health.

V. Continuing Education and Health Policy and Management Training

We urge the Committee to include provisions in S. 2375 and S. 2144 that target funds for continuing education programs designed to train on-the-job professionals in the latest developments of health policy, management, finance and administration. S. 2375 enables the Schools to use Section 799 funds for this purpose; S. 2144 allows similar usage in Section 747. However, recent enactment of Federal health and environmental laws, plus expanding expectations for health, increased public participation in personal and national health affairs, greater demand for cost containment and improved health services management, and the national debate for passage of a national health programs, all have created a demand for the upgrading of skills for professionals working in health promotion and disease prevention and health administration fields. According to recent reports, of the approximately 150,000 people from the public health work force, only 25 percent are graduates of Schools of Public Health or other health professional training programs. One-half of the total require short-term re-training in order to help them keep up with the growing complexities of health programs and the ever increasing base of knowledge and technology. Present authorization levels in both bills are not adequate to meet this need.

There is an urgent need for trained policy planners and managers throughout the health system, including many in public and private non-profit agencies and institutions that are not directly engaged in the provision of hands-on care for the ill, but do impact on the availability, quality and cost of medical care, and on health services generally, including disease prevention, health promotion, and protection of the public from hazards to health (radiation, toxic substances, air and water pollution, etc.).

Although both bills allow funds to be used to develop continuing education programs in the traditional sense, ASPH urges the Members to support other provisions establishing programs that effect constructive change by widening the perspectives and increasing the management capabilities of senior and mid-level executives and leaders who are responsible for directing health agencies such as HMOs, HSAs, community health centers, hospitals, state and local health departments, environmental agencies, among others.

VI. Facilities Maintenance

ASPH urges the Committee to approve provisions in the health manpower act that provide assistance to Schools of Public Health for construction, renovation and/or refurbishment of facilities to provide appropriate teaching and research environments for students and faculty. Both bills under consideration would support the Schools in expanding their programs in vital public health disciplines to incorporate the necessary elements which ASPH maintains are so desperately needed.

However, present plans to terminate grants for construction and extremely limited funds for renovation of teaching facilities ignore the implications of federal laws, initiatives and the Surgeon General's report, which will stimulate the growing demand for public health manpower. If assumptions regarding growing demands are true, the Schools of Public Health will need the construction grants in order to expand their facilities to accommodate the necessary increase in enrollments. Many of the 21 Schools of Public Health are operating at their capacity level. Expansion of enrollment to meet the growing demand will mean overcrowded and inappropriate teaching conditions.

VII. Health Personnel Data and Manpower Projections

ASPH supports Section 708 in S. 2375 and Section 708 in S. 2144 that ask the Secretary to collect, compile and analyze data on all sectors involved in the health services delivery system. With the demands being placed on the Schools of Public Health to provide data to the executive and legislative branches of the Federal government, it becomes imperative that a centralized system of data collection be continued. At the present time such a system is operating and can provide information on applicants, students, graduates, faculty research projects and expenditures in Schools of Public Health. Because of the need for authentic data produced in a timely fashion, federal funding is necessary to maintain surveillance on public health manpower production in the Schools of Public Health. Also, this type of data collection and surveillance needs to be extended to other schools and programs that produce specialized health manpower personnel.

Further in an effort to monitor the ability of the production system to fill manpower requirements of the work force, studies must be undertaken to assess public health manpower requirements in all sectors of the health delivery system, especially in the public sector. Contrary to the other health professions (physicians, nurses, dentists, pharmacists, veterinarians,optometrists, etc.) no federal studies have been undertaken on the need for the present or future supply of public health workers.

ASPH urges the Committee to provide assistance to not only conduct studies to determine the demand for public health personnel, but to determine the cost of educating and training community and public health workers, as well as identifying functional and geographic areas in which there are shortages in national priority needs.

VIII. Other Bills of Concern to ASPH

ASPH supports, in general, S.2378, the "Health Care Management and Health Care Personnel Distribution Improvement Act of 1980". It is consistent with the thrust of the other bills (S. 2375 and S. 2144) that target Federal assistance to train personnel needed to carry out programs in manpower shortage areas.

The Administration's bill proposes to end capitation but it does continue to provide student support and curriculum development monies to Schools of Public Health and programs in health administration.

ASPH is puzzled as to why the Administration proposes to incorporate specific authorities (Sections 748, 749, 791, and 792) into the more general authority for special projects (Section 788), and yet stipulate in the bill and in FY 1981 budget justification documents that all of the funds appropriated under Section 788(d) be earmarked for public health and health administration. If public health is a high priority area in the Administration's game plan (Healthy People), then the specific authorizations for public health traineeships and special projects should be left intact in the bill.

IX. Summary

ASPH urges the Committee to include references to public health in the preamble of the bill that would amend P.L. 94-484. ASPH suggests that the bill should be complementary to the Surgeon General's report Healthy People:

> It is the thesis of this report that further improvements in the health of the American people can and will be achieved -- not alone through increased medical care and greater health expenditures -- but through a renewed national commitment to efforts designed to prevent disease and to promote health.

Further, the preamble should note another finding in Healthy People:

> In the field of public health, in contrast to personal health, manpower shortages are believed to exist in some key fields, including occupational health, epidemiology, biostatistics, and health services administration.

In summary, the ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The Schools (i.e., through their students, graduates, researchers, faculty and community service programs) will not only help prevent illness but will also help slow down the rapidly escalating costs of medical care. Providing basic institutional and student support is a means whereby the Federal government can share the costs with state and private institutions for the training of public health personnel to manage and operate governmental health programs. Public health is a public responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH thanks the Members of the Senate Labor and Human Resources Subcommittee on Health and Scientific Research for the opportunity to present its views on the extension and revision of P.L. 94-484, the "Health Professions and Educational Assistance Act".

Senator **METZENBAUM**. Dr. Holder?

Dr. **HOLDER**. Senators, good morning.

I am Lee Holder, dean of the University of Tennessee College of Community and Allied Health Professions and president of the American Society of Allied Health Professions. It is in the latter capacity that I appear here today.

You have been provided copies of the society's full statement; I ask that the statement be included, with the several following summary comments, in the record of this proceeding.

A few words about allied health and the society:

Allied health is more than 3 million health-care practitioners, educators, and researchers—about two-thirds of the Nation's total health-care work force. It is close to 100 separate and distinct professions, ranging—in terms of the amount of postsecondary education considered prerequisite to practice—from the certificate and associate degrees, through the baccalaureate and masters levels, to the doctorate. It is professional involvement in virtually every aspect of health care—the emergency medical technician at the scene of an accident; the audiologist doing hearing screening and diagnosis among the elderly; the medical technologist and other clinical laboratory personnel, running tests in a hospital lab; the physical therapist, speech pathologist and rehabilitation counselor involved in long-term therapy with stroke victims; the respiratory therapist, the radiographer, and the dialysis technician, concerned with medical instrumentation; the nutritionist and dietitian and environmental engineer concerned with community and environmental health promotion and protection; and the industrial hygienist, involved in the promotion of workplace health and safety; the hospital administrator and medical records professional, managing health systems of various kinds and complexities; the toxicologist and biostatistician, involved in important research and development initiatives. This, in all its diversity, is allied health.

My society, the American Society of Allied Health Professions, is the national scientific and professional association which represents this great diversity and all its great potential. Our individual members come from all the allied health fields. Our professional organization members are most of the major national professional associations, each representing a single allied health field. Our institutional members are the Nation's allied health schools and many of its training and service-delivery programs.

Our testimony is based primarily on the recommendations of two recent reports—one, the product of the Federal Government's own Bureau of Health Manpower; the second, the product of a 2-year study by the W. K. Kellogg Foundation-supported National Commission on Allied Health Education.

Both were written to assist Members of Congress and other health-care policymakers in shaping the future of allied health. Both view allied health training and services as essential elements of the Nation's health-care education and service-delivery systems.

Both see a major allied health-support role for the Federal Government.

Based on these two reports, our testimony responds to the allied health-related authorizations of existing law and the proposals introduced by Senators Kennedy and Schweiker.

In particular, we are concerned with the current law's definition of the term "allied health"—it is inappropriate and, we think, unnecessary.

Senator Schweiker has made an excellent attempt at rectifying the problems with the present definition and we applaud that effort. Our other recommendations, on pages 15 through 23 of our statement, relate to the National Advisory Council on Health Professions Education, important data collection needs, areas for project-support emphasis, the continuation of an authorization for training institutes in allied health, the critical need for an increased emphasis on ethnic-minority group involvement in allied health training, the National Health Service Corps, the national priority initiatives contained in both the Schweiker and Kennedy bills, and the filling of what the Government has called "significant national allied health shortages."

Two final words:

First, we also have reviewed the administration's health-manpower proposal, and find it lacking in the extreme in an understanding of and sensitivity to health care and health manpower realities and needs.

Second, we are aware of the very recent major changes in the organization of the Bureau of Health Manpower—changes which point to the eventual dismantling of that important agency. We deeply regret these changes were made without any public input whatever. We are also concerned, and we believe the Congress should be, that they were made without congressional involvement.

We appreciate your interest.

Thank you.

[The prepared statement of Dr. [illegible]lder follows:]

STATEMENT
OF
THE AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS
ON
LEGISLATION TO AMEND AND EXTEND CURRENT HEALTH & MANPOWER TRAINING AUTHORITIES CONTAINED IN TITLE VII OF THE PUBLIC HEALTH SERVICE ACT (AS AMENDED)

Presented to
The Subcommittee on Health and Scientific Research
of the
United States Senate

by
Lee Holder, Ph.D.,
President, American Society of Allied Health Professions
and
Dean, School of Community and Allied Health Professions,
University of Tennessee (Health Sciences Center), Memphis, Tennessee

Wednesday, March 12, 1980

I am Lee Holder, president of the American Society of Allied Health Professions (ASAHP) and dean of the University of Tennessee School of Community and Allied Health Professions in Memphis.

The Society is a national scientific and professional organization composed of three councils, each representing a different aspect of Society membership. Our Council of Educational Institutions is made up of Allied Health schools and educational programs which offer Allied Health degrees ranging from the certificate (through the associate, baccalaureate and master's degrees) to the doctorate. National professional associations and clinical service programs comprise the Society's Council of Professional Organizations. Our third council, the Council of Individual Members, is composed of clinicians, educators and administrators from all of the various Allied Health professions. Taken together, the Society's councils are as representative of Allied Health--its strengths, its needs and its tremendous diversity--as is possible.

The Society is pleased to have been invited to offer its views on proposals to amend and extend present statutory authorities for federal support of health-manpower education, and I am honored to represent the Society's membership before this panel.

BHM and NCAHE Reports

Our testimony today is based, in significant part, on two reports dealing with manpower-training realities and needs in the Allied Health professions. The first of these is the product of the Health Resources Administration's Bureau of Health Manpower. Entitled A Report on Allied Health Personnel and released to the public only last week, it was prepared under the authority of section 702(d) of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), as amended, for the Senate's Labor and Human Resources Committee and the Committee on Interstate and Foreign Commerce of the House of Representatives.

The second report is the product of the National Commission on Allied Health Education, a blue-ribbon panel of health and education experts which, for a two-year period ending late last year, focused its talents and energies on the development of the Allied Health movement since the mid-sixties and on how that movement--still a relatively new force in our health care and health-manpower education systems--might best function in the decade of the eighties. Entitled The Future of Allied Health: Alliances for the 1980s,it will be published by Jossey-Bass, Inc. Publishers, in the next several weeks. The Society will be pleased to provide copies to Members of Congress and appropriate congressional staff members. The Commission's report,like that of the Bureau of Health Manpower, is intended principally as a reference book for policymakers whose [illegible] will affect Allied Health education and service delivery in the years [illegible]. The Commission was chaired by former University of Kentucky president Frank G. Dickey; its product and the two years of study and deliberation which preceded the report's completion were supported by the W.K. Kellogg Foundation of Battle Creek, Michigan.

The Allied Health Community

The Allied Health professions are heterogeneous in the extreme, differing in the competencies they require, their respective requisite educational preparation, the scientific foundations for their knowledge bases, and the clinical and educational roles which they play in the nation's health-care delivery system.

Required competencies vary from the performance of relatively routine tasks to the highest levels of education and service-delivery administration and the generation of new knowledge through research. Similarly broad is the range of educational preparation the Allied Health professions require--from limited post-secondary training to postdoctoral study. The time required for such preparation ranges from several months to more than a few years.

The scientific foundations of Allied Health profession expertise range from the biological and chemical sciences (*e.g.*, clinical laboratory professionals) to the social sciences (*e.g.*, social workers and clinical psychologists) to combinations of the physical and social sciences and the humanities (*e.g.*, speech pathologists, rehabilitation counselors).

Some Allied Health professionals are involved primarily in institutional patient care, others in community health promotion and protection, still others in health-care research, manpower training, and education and service delivery administration. The range of Allied Health services includes:

- *emergency services* (*e.g.*, emergency medical technicians, physician assistants);
- *reception and screening* (*e.g.*, medical and dental secretaries, medical office assistants);
- *initial evaluation and diagnosis* (*e.g.*, audiologists, physician assistants, dental hygienists, mental health technologists, medical social workers);
- *continued assessment as part of treatment* (*e.g.*, physical therapists, occupational therapists, respiratory therapists, speech pathologists, audiologists, dietitians);
- *testing* (*e.g.*, medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- *acute care therapy* (*e.g.*, operating room technicians, obstetrical assistants, surgeons' assistants);
- *long-term care therapy* (*e.g.*, occupational, physical and other therapists; personnel in mental health and social services, counseling, speech pathology, audiology, nutrition);
- *medical instrumentation* (*e.g.*, radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, opthalmic dispensers, dental laboratory technicians);
- *community health promotion and protection* (*e.g.*, nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);
- *environmental health promotion and protection* (*e.g.*, sanitarians, environmental health technicians, sanitarian aides, environmental engineering assistants);

- control and elimination of hazards in an institutional or industrial setting (e.g., audiologists, health physicists, health care facility housekeepers, industrial hygienists);
- health systems management (e.g., hospital administrators, health planners, medical records personnel, medical computer specialists);
- research and development (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

An essential feature of Allied Health education since the 1960s has been its rapid change and expansion, characterized by the following three major ingredients: First, there has been a tremendous growth in the number of programs, particularly in collegiate settings, which has paralleled the great expansion of two-year colleges and the growing popularity of vocational programs (in 1966, there were an estimated 2,500 collegiate programs; today there are over 8,000); second, the distribution of programs has changed--hospitals and other health-service settings still play an important role, but the greatest program growth has occurred in such other settings as medical centers and universities, two-year colleges, vocational technical institutes, and private career schools; third, a dramatic expansion of knowledge and skill requirements has led to increased diversification of educational requirements.

In 1976, the latest year for which there is adequate survey information, there were about 14,000 formal postsecondary programs for Allied Health personnel. Of these,

- 52 to 54 percent were in collegiate settings,
- 33 to 35 percent were in hospitals,
- 10 to 12 percent were in postsecondary non-collegiate institutions, and
- one percent were in the armed forces.

Over half of the nation's 3,000 higher education institutions have at least one Allied Health program. Such programs are contained in about 90 percent of the nation's research universities and doctoral-granting institutions, as well as in large proportions of comprehensive colleges and universities, free-standing medical centers, and two-year colleges. Significantly more than half of all Allied Health programs in collegiate institutions award degrees at the baccalaureate or higher level.

It may be important to point out here that these patterns of education for the Allied Health professions have grown out of practice needs, rather than from abstractly determined sets of values. Thus, the history of Allied Health education, brief as it is, is closely related to the history of the occupations themselves. The burgeoning of the Allied Health professions and of Allied Health education is the product of increased and increasing health-service demands and the explosive growth in health science and technology.

Manpower data is not what it might be-- what we hope it can and will be-- in the area of Allied Health. Still, we can say with reasonable assurance that, as of 1978,an estimated 3.5 million individuals (nearly 66 percent of the total health-care work force) could be classified, in the broadest sense, as Allied Health practitioners. The core of this population--the professions in which the federal government has invested the bulk of its Allied Health manpower-training funds and which, generally, require collegiate preparation ranging from the associate degree to the doctorate--has grown from 442,000 in 1966 to approximately 1,026,000 in 1978. This 132-percent rate of growth compares with a 76-percent growth rate for all health professionals.

Yet despite this growth, HRA's Bureau of Health Manpower tells us that there are still clear and significant national Allied Health manpower shortages in such professions as audiology, speech pathology and respiratory therapy. And though the data is not definitive, it also appears to the Bureau that there still may be national shortages of dietitians and dietetic technicians, radiation therapists, physical therapists, occupational therapists, and formally-trained dental assistants.

The Bureau goes on to report that, even in professions in which the overall national supply appears to be adequate, local or transitory shortages continue and employers across the country encounter difficulties in filling "critical Allied Health positions", requiring highly qualified professionals and exceptional skills.

Federal Support of Allied Health Education

Federal support for Allied Health manpower training was first authorized in 1966 by the Allied Health Professions Personnel Training Act. During the first four years of operation under its authorities, the statute put primary emphasis on increasing the number of training programs and professionals. In the early seventies, however, the statute was amended, its emphasis shifted: Basic improvement grants, which encouraged the establishment of new scholastic programs, were abandoned in favor of new focuses and initiatives, relating more to the provision of quality Allied Health education and health service than to the production of increased numbers of Allied Health professionals. The shift clearly was occasioned by public economic policy, and not by evidence that manpower needs had been met--there were at least as many "significant" national professional-area shortages at the start of the seventies as there are today.

The new funding focuses were on special educational projects for Allied Health training programs (interestingly,one special project focus addressed the need for the "establishment of new roles and functions for Allied Health" personnel), on faculty development through a mechanism called "advanced traineeships", and on the recruitment to the Allied Health professions and retention of ethnic minority-group members.

Funding authorizations which followed the shift from the early basic improvement grants to the special target grants and contracts were moderate, to say the most. But this moderate support soon became virtually no support at all. In fiscal year 1973, for example, Congress provided $30.2 million to support Allied Health planning, development and operation of such (sections 796,797 and 798) projects as the establishment of regional systems for coordinating and managing Allied Health training; of new and improved methods of credentialing Allied Health Personnel; of recruitment, training and retraining programs; of career ladders and other programs of advancement; of continuing education programs; of faculty training institutes; and of ethnic minority-group member recruitment. Last year, following an Administration call for zero funding of Allied Health manpower-training programs and projects, the Allied Health community was able to win congressional support for a $10 million fiscal 1980 appropriation for these Part G (Title VII) initiatives. This year, the Administration is calling not only for a zero funding level for fiscal 1981, it also is recommending that the monies appropriated for the present fiscal year should be rescinded.

The Administration's rationale for these zero-funding recommendations makes no sense at all. Administration spokesmen list cost effectiveness, the delivery of services to unserved and underserved areas of the country, disease prevention and health promotion, and the involvement of ethnic minority-group members in health-care education and service delivery as the major national health-care objectives. Yet, in what seems the same breath (expelled through the other side of its mouth), the Administration urges Congress to refuse any support for that segment of the health manpower population which is best prepared and best able to address these objectives.

In another jump off the cliff of logic, the Administration argues that, inasmuch as there are no manpower shortages among the Allied Health professions, "continued federal involvement in basic Allied Health training support" is unwarranted. The argument both denies and defies the reality of the Report of the Administration's own health-manpower agency, which not only makes a "case for continued Federal activity on behalf of allied health personnel," but also lists a relatively large number of key Allied Health professions in which there are "significant national shortages." But more--the Administration also seems to have overlooked the fact that federal Allied Health manpower-training funding is expressly intended by statute for special-target projects and not for basic education support. Indeed, such basic support hasn't been available to the Allied Health professions for the better part of a decade!

Some might argue that the $276 million invested by the federal government (since 1967) in Allied Health manpower training is not only a substantial amount, but an appropriate amount as well. Substantial it well might be; appropriate it most assuredly is not. The $276 million figure-- the federal government's total 14-year commitment to two-thirds of the nation's health-care workforce--represents merely four percent of the total federal investment in health-manpower training and development. From its beginnings, Allied Health has been relegated by the federal government to but a cubby hole in the great mansion of health-care education. Today, there's an eviction notice on our small door. We hope this Subcommittee will tear down that notice and, in doing so, give notice of its own that Allied Health can, must and will be counted on by the federal government as a major partner in the development of an effective manpower-training and service-delivery effort.

Bureau of Health Manpower Recommendations

The Society believes that the federal government must assume a leadership role in helping fill what HRA's Bureau of Health Manpower terms as "significant national [Allied Health] shortages."

In addition, we see a major federal responsibility in the fulfillment of these of the Bureau's Allied Health related recommendations:

1. "Information including statistical data on allied health personnel requires continued improvement, by larger investments and coordinated activities...

"Particularly, data are needed with which to determine the nature and extent of 'critical vacancies' and specific skills shortages, and to plan appropriate local, State, regional, or national remedies.

"More data are needed to evaluate the effects of governmental and private sector regulation upon personnel utilization, health care costs, quality of service, and demands for continuing education.

"Better data are needed on minority participation in the work force.

2. "Special attention to the allied health personnel problems of small health care institutions is required, to ensure that regulatory and other constraints do not interfere with access to and the quality and continuity of patient care. Additional resources are needed with which to investigate the nature, extent, and impact of these problems, and to devise solutions as may be necessary.

3. "The cost-saving potential of more efficient use of allied health personnel should be thoroughly explored through well-designed and controlled studies carried out in various work settings and not hindered by current legal limitations on the use of personnel.

4. "As personnel standards are changed, training programs must be revised. This requires national coordination and encouragement.

5. "As manpower standards change, personnel working in the field who cannot meet new and more rigorous qualifications must be provided with opportunities to improve their competencies. Support to develop training materials and procedures that will reach the employed work force is necessary.

6. "Methods of testing of individuals to determine competency in the health field require improvement, through additional research, development, and validation, with Federal leadership.

7. "To the extent necessary to ensure adequate numbers of these personnel equitably distributed among and within States, Federal programs must encourage comprehensive State programs to identify and act upon problems of maldistribution and undersupply.

8. "There should be established within the Department (i.e. HEW) the function of review and approval of all Federal policies and actions that lead to or encourage new health occupations or specialties.

9. "There should be established within the Department the function of review and assessment of all Federal policies and regulations that affect the demand for or utilization of health personnel.

10. "Improvement of specific clinical competencies of allied

health personnel is required, through advanced and short-term training and through self-instruction, particularly for the following subjects or functions:

- long-term care of the elderly and chronically ill,
- hospice care,
- disease prevention and health promotion, and
- application of new technologies.

11. "Improvement in nonclinical competencies of allied health personnel is required, through advanced and short-term training and through self-instruction, particularly in:

    - teaching
    - educational program planning,
    - administration and supervision, and
    - performance evaluation and assessment.

12. "Maintenance and further development of allied health training centers should be encouraged so that they carry out essential interdisciplinary coordinating and planning activities.

13. "Additional allied health training centers in institutions with predominantly minority enrollments should be established.

14. "Activities for the recruitment of and assistance to minority students in allied health training programs should be increased.

15. "The MEDIHC program (Military Experience Directed Into Health Careers) to place veterans and other allied health personnel in critical vacancies, especially in small and rural institutions, should be continued.

16. "Statewide and educational system wide planning for allied health occupations education and training, through grants and cooperative agreements, should be encouraged and supported.

Recommendations of the National Commission on Allied Health Education

The report of the Kellogg Foundation-supported National Commission on Allied Health Education is summarized in the brochure which I have attached to copies of my statement, and which I hope can be included as a supplement to my testimony in the record of this proceeding. As you and other readers of the record will note, the Commission lists 15 "primary recommendations" which it views as crucial to the future of Allied Health education and service delivery. The most critical of these 15, in our view, is the last, which offers that "Significantly increased funding for allied health should be provided at the federal, state and local government levels, and from private resources." Absent the recommended increase, the achievement of any of the remaining 14 primary Commission recommendations is impossible.

In addition to its primary urgings, the Commission offers 63 "procedural recommendations"-- proposed priority action initiatives designed to implement the more general primary recommendations. Listed below are those of the procedural priorities which the Commission views as responsibilities of the federal government:

> Priority #1-- Link education to practice and end unnecessary expansion of entry-level requirements. Today, a gap exists between declaration and attainment of the goal of relating education to performance objectives based on health service demands. Current knowledge of practice needs is limited for most Allied Health professions. Consequently, educational content is determined by expert judgement and the tendency to err in favor of too much rather than too little education.
>
> • The federal government should support role-delineation projects and activities which lead to the more effective use of role delineations (e.g., workshops to develop a common methodology of role delineation so that results can be compared accross professions and commonalities in function and knowledge requirements can be identified).
>
> • The federal government should support projects to improve the methodology of performance-based testing, which can be used to provide alternate routes to certification (i.e., other than formal education) and to base the right to practice on demonstrated competency.
>
> Priority #2-- Assure flexibility of health professionals. In a rapidly changing health service delivery system, adaptability is essential. A broad foundation is particularly important in professional areas requiring lengthy preparation. Flexibility may be developed through the acquisition of a knowledge base that is generic to health occupations, or of the competencies required to perform in more than one occupational role. Today, few educational programs provide students with preparation of this kind.
>
> • The federal government should support projects to design and implement curriculum modules based on role delineations for two or more occupations.

- The federal government also should support activities for sharing information and experiences of programs which currently prepare students for more than one occupational role.

Priority #3-- Include new subject matter designed to meet new service demands. Trends in health service and changing health priorities indicate the need to include subject areas which are not now a standard part of most Allied Health curricula: Human values, prevention of illness and promotion of health, and health-service delivery systems (roles and functions of health personnel, legal risks, patients' rights, cost effectiveness, and quality control). New instructional materials are needed in these areas for the various levels of health professions preparation.

- The federal government should support projects to develop and disseminate interdisciplinary instructional modules in human values, the prevention of illness, the promotion of health, and health-service delivery systems. The trial implementation of modules also should be encouraged.

Priority #4-- End unnecessary proliferation of new occupations and programs. The current tendency to create new occupations to meet each newly identified health-service need or each new health-service technology is wasteful and results in the increased splintering of health-service functions, impairment of health-service quality, and increased health-service delivery costs. Educational programs have virtually no financial incentives to seek alternative ways to meet new health-service needs.

- The federal government should support projects designed to demonstrate ways to meet new health-service needs without creating new specialties, such as:

  -- short-term supplemental preparation for existing health personnel,

  -- short-term preparation in health applications for college graduates who majored in relevant nonhealth fields (*e.g.*, social services, education),

  -- inservice training programs for persons employed in nonhealth occupations who have contact with the patient/client population, and

  -- incorporation of new objectives in existing programs.

Priority #5-- Assure continuing competency of health personnel. Although there has been an explosion of activity in the area of continuing education, information on continuing education in Allied Health has never been compiled systematically, in a way which will facilitate cross-occupational exchange.

Many outstanding issues remain to be resolved (e.g., needs assessment, quality assurance, financing). A forum for collaborative problem-solving is needed.

- The federal government should support the establishment of a National Coalition for Continuing Education to provide leadership at national, regional, and local levels. This voluntary coalition would be a forum for collective problem solving, information-sharing, and research; it would facilitate, rather than regulate educational processes. Participants would represent all groups concerned with continuing education (e.g., educational institutions, professional associations, practitioners, employers, and accrediting, certifying, and licensing bodies).

Priority #6-- Integrate clinical and didactic education and expand the range of clinical education methods. It is essential that clinical education be viewed as part of the total experience in preparing personnel for the Allied Health professions. Today, however, students are often left to their own devices in obtaining and pursuing clinical learning experiences, and there is no assurance that the quality and range of clinical experience adequately complement the didactic experience. Further development of clinical education materials which can be used in a classroom setting is needed to increase student opportunities for translating theory into practice at all stages of a training program; such materials would both enhance and expand practical learning acquired in actual practice settings.

- The federal government should support the development and demonstration of alternative methods of learning for clinical competence (such as simulated clinical learning programs and programmed laboratory experiences), which are designed to better integrate clinical practice into the total educational experience and to ensure clinical competency in a period of decreasing educational program access to hospitals and other clinical facilities.

- Support also should be made available for intensive research on methods of clinical education which are designed to identify the types of professional learning most dependent on practical experiences and to ensure that the clinical education relates to a wide variety of practice needs.

Priority #7-- Improve articulation in Allied Health education. Continuity between various educational levels and study disciplines benefits both society at large and the consumer of educational programs. It is cost effective to include in each phase of education only those aspects of required learning that have not already been attained; it is wasteful to pay for the unnecessary repetition of learning experiences. In spite of a national trend toward more flexible admissions and transfer policies, Allied Health administrators do not have the tools to make articulation work.

- The federal government should support development of such articulation tools as challenge examinations for Allied Health education subject matter of a multidisciplinary nature.

Priority #8-- Increase the representation of ethnic minority group members in the Allied Health professions. Increasing the representation of minorities in the Allied Health professions is important to meet the health needs of diverse cultures and ethnic groups. Moreover, Allied Health professions represent an excellent avenue for social mobility for disadvantaged minorities, because they are among the limited number of professions and occupations in the economy for which the employment outlook is almost uniformly favorable.

- The federal government should support student aid programs and special projects for the disadvantaged (especially racial minorities) and the handicapped.

Priority #9-- Build the capability for leadership and innovation. Because of the dynamic nature of health-care delivery and rapidly changing practice needs, Allied Health education must not remain static. It is essential to develop the capability for leadership and innovation. More support is needed for the activities on which future improvements in Allied Health education and services are dependant.

- The federal government should support advanced programs on pilot or demonstration bases for the preparation of master clinicians and research on the effect of clinicians on the cost and effectiveness of health services.

- Support also should be made available for the establishment on demonstration bases of field stations, the purpose of which will be to increase the volume, quality, relevance, and utilization of research in Allied Health clinical services.

- Support also should be directed toward continuing education programs which teach planning and management skills to Allied Health professionals already in practice, including circuit-riding courses for practitioners in rural areas.

- Support is additionally needed for the development of institutes and workshops for administrators and faculty on a wide range of topics, including ways of relating education to practice needs and methods of attracting and retaining ethnic minority-group students.

- Finally, the federal government should support the establishment of 5 or 6 regional centers for research and development in Allied Health.

Priority #10-- Improve the information base for planning. Planning for Allied Health education at all levels currently occurs in an information vacuum, which results in wasteful duplication of effort. Manpower data are incomplete and outdated. Biennial inventories of collegiate Allied Health programs and programs in hospital settings are useful, but very little is known about Allied Health education which takes place in other settings.

- The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distribution of health manpower in all professional areas, including information on projected openings.

- Support should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which offer formal post-secondary education programs.

- Support also is required for the development of a system of cost accounting for Allied Health programs, designed to identify actual program costs, costs-per-student, and comparative program and institutional costs to be used by educational institutions, health and education planners, and professional associations at local, state, and national levels.

- The federal government should support research on:

  --The cost effectiveness of Allied Health educational processes,
  --The impact of various institutional environments and program characteristics on competency attainment,
  --Allied Health faculty characteristics and continuing development needs, and
  --Methods of making Allied Health education responsive to such special service needs as those of rural and urban underserved areas.

ASAHP Recommendations for Statutory Change

Following are the elements of change which the American Society of Allied Health asks this Subcommittee to include in its version of extended and amended health manpower-training authorities. The elements generally incorporate amalgamations of the recommendations developed for the Subcommittee and other policymakers by both the Bureau of Health Manpower and the National Commission on Allied Health Education.

1. The Definition of "Allied Health Personnel" [Section 795 (1)] : Current statutory language defines "Allied Health personnel" as "individuals with training and responsibilities for (A) supporting, complementing, or

supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (B) assisting environmental engineers and other personnel in environmental health control and preventive medicine activities." The extant statutory portrait of Allied Health professionals is completed in the section 795 (2) definition of "training center for Allied Health professions," which lists as the only examples of those professions "medical technology, optometric technology, and dental hygiene."

The portrait is inappropriate and, as we shall offer later, largely unnecessary. It is inappropriate for three reasons:

> a. The definition uses the term "personnel" rather than the term "professional." Physicians and dentists and unidentified others are "professionals;" Allied Health practitioners are "personnel." The distinction is inappropriate and, we think, derogatory. We note with pleasure Senator Kennedy's attempt to end the distinction by referring to all health-care practitioners affected by title VII as "personnel." His use of the term "professionals," applied without prejudice, would have been at least as acceptable.
>
> b. The definition suggests that Allied Health professionals always and everywhere work for or under the supervission of physicians, dentists and environmental engineers. That's simply not true.
>
> c. Finally, the definition puts forward as explicit examples of Allied Health practitioners not the physical or occupational therapist, the audiologist or speech pathologist, the dietition or clinical psychologist, but rather the individuals who function (medical technologists excepted) as aides and assistants. The examples are not inaccurate--these professionals are Allied Health practitioners; they are, however, not nearly as representative of the Allied Health fields as other choices would be.

Let me cite just one example of the unfortunate effects of the present definition's inappropriateness: The American Speech-Language-Hearing Association has long suggested to its members that they should not seek federal training assistance under the Part G Allied Health authorities of Title VII. To do so, the Association has said, would be to admit that speech pathologists and audiologists are something less than "professional." Training program directors who are members of that distinguished Association agreed--principle was of preeminent importance. It should come as no surprise, then, that speech pathology and audiology are two of the three Allied Health professions in which, according to the Bureau [illegible] Manpower, there are critical manpower shortages nationwide.

Senator Schweiker's proposal (S. 2144), in its section 700 (a), attempts to rectify the definition's inappropriateness by deleting, in the subsection (8) definition of "training center for Allied Health" and "school of Allied Health," all references to examples of the Allied Health professions. We strongly endorse the Senator's subsection (8) definition.

In his bill's subsection(7), Senator Schweiker has attempted to complete the portrait of "Allied Health personnel" by detailing who they are not (i.e., "graduates of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health and graduate programs in health administration"). We applaud the Senator's effort. What we would prefer, however, is the omission of any definition of "Allied Health personnel" [as in section 795 (1) of the Act and 700 (a)(7) of S. 2144]. Medical personnel are not defined, nor dental personnel, nor podiatric personnel; rather the schools which train such personnel are defined. We believe that the same standard should apply to the Allied Health field and, therefore, urge the Subcommittee to--

> delete section 795 (1) of the current statute and amend the current section 795 (2) by substituting, in lieu thereof, subsections (A), (B), and (C) of section 700 (a) (8) of proposed S. 2144. Subsection (D) of existing section 795 (2) should be retained.

2. Advisory Council Inclusion of Allied Health Representation:

Both the Kennedy and Schweiker proposals would amend existing section 702 (a) language so as to accommodate representation on the National Advisory Council on Health Professions Education by a representative of Allied Health schools, and potential representation by a student enrolled in an Allied Health curriculum. We endorse these proposals. The Council has gone too long without a representative of the educational institutions which train the largest segment of the health-care workforce. We, therefore, recommend that the Subcommittee adopt the proposals of Senators Kennedy and Schweiker which would--

> add representatives of Allied health schools (and of the student bodies of such institutions) to those health profession school representatives presently listed in section 702 (a) of Title VII as members of the National Advisory Council on Health Professions Education.

3. Data Collection in Allied Health: According to the recent reports of the Bureau of Health Manpower and the National Commission on Allied Health Education, support for data collection in Allied Health should be at the top of the federal government's Allied Health support agenda. Says the Report of the Bureau of Health Manpower:

> "There are insufficient data about allied health personnel at the local, State, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service costs, and work force quality are needed. Data on improvements in supply, work force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, Federal support appears to be a decisive factor."

According to the National Commission:

> "The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distribution of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which offer formal post-secondary education programs.

The Commission's emphasis on data collection from "all occupational areas [and] settings which offer formal postsecondary education programs" merits special note. At present, the federal government supports Allied Health related data collection which relates only to Allied Health schools defined in existing section 795(2) -- i.e., schools which award the associate or baccalaureate or higher degree. There is, however, a large number of certificate-awarding Allied Health institutions (and an increasing number of Allied Health aide, assistant, and orderly-type graduates of such schools) regarding which data is not being collected. Clearly, this data needs to be gathered and analyzed. It should be and, we would urge, can be gathered without altering in any way the statutory definition of the Allied Health schools which are appropriate recipients of the federal training support.

There also is a pressing need for feasibility studies on the collection of data relating to ethnic minority-group member involvement in Allied Health training and practice. Data on approaches to career counseling, recruitment, admissions, and retention of minority-group students in training programs are required, so that we can understand (and deal with) the reality of greater student involvement at lower levels of training. We also need definitive studies on the impact of minority institutions on the overall Allied Health manpower pool and on the reasons for unique minority-group member practice patterns and geographic distribution.

In view of the foregoing, the Society asks the Subcommittee to --

> either amend the existing data-collection language of 708 or add a new section to Part G to accommodate the need for the collection of Allied Health related data from schools of Allied Health (including post-secondary nonprofit and proprietary institutions which grant practice "certificates" in Allied Health disciplines), including data relating to production, recruitment, reimbursement, utilization, service costs, workforce quality, educational standards and methods, and opportunities for minorities.

4. Allied Health Project Support: Existing section 796 authorizes $26 million in grants and contracts to "eligible entities" for special projects which are detailed in subsection (a)(1) of the section. With one notable

exception (i.e., projects to establish "new roles and functions of allied health personnel"),--

> the purposes of section 798 should be retained in the Subcommittee's final legislative proposal. In addition, the following project-support emphases should be added to those already enumerated: projects which focus on Allied Health role delineations and related interdisciplinary curriculum modules; on meeting new health-service needs without creating new specialities; on the development of mechanisms for interdisciplinary articulation; on the use of Allied Health practitioners in containing health-care costs; on the Allied Health related needs of unserved and underserved areas; and on curriculum offerings in health promotion, disease prevention, geriatrics, and health planning. The authorization levels for existing section 796 should be $30 million for fiscal 1981, $32 million for fiscal 1982, $34 million for fiscal 1983, and $36 million for fiscal 1984.

5. Training Institutes in Allied Health: Existing section 797 authorizes $5.5 million for the current fiscal year for institutes generally designed to accomodate the "advanced" learning needs of Allied Health practitioners who, principally as a result of the rapid expansion of the Allied Health fields and increases in the numbers and varieties of Allied Health opportunities and initiatives, find themselves in new educational, supervisory or administrative settings. The Society believes that this emphasis should be continued and, therefore, recommends that the final Subcommittee proposal should--

> include existing section 797 through fiscal year 1984 at annual authorization levels which are equal to that of the current fiscal year.

6. Ethnic Minority-Group Allied Health Education: As the National Commission on Allied Health Education points out, the Allied Health professions, because they are among the few professions in the economy for which the employment outlook is almost uniformly favorable, "represent an excellent avenue for social mobility" on the part of ethnic minority-group members.

Moreover, notes the Commission, "minorities are substantially underrepresented in educational programs for the relatively high-level Allied Health occupations (*i.e.*, baccalaureate and advanced degree levels)." Minority Allied Health training programs also are underrepresented -- among programs receiving Allied Health training assistance from the federal government. In the last year for which data are available (1975), the 563 Allied Health discipline programs situated in minority institutions represented 10 percent of the total Allied Health program offerings. Yet minority institutions received only six percent of Allied Health training assistance made available through the Bureau of Health Manpower. The Society asks that the Subcommittee include in its final legislative proposal authorizations designed to--

> provide student support for disadvantaged ethnic minority group members enrolled in Allied Health education programs (especially in baccalaureate and graduate programs), and special program support for Allied Health education programs in traditionally and predominantly minority institutions. In addition, the special recruitment and related emphases of existing section 799 should be continued at the current authorization level.

Senator Kennedy's proposed section 787 represents an exemplary attempt to accommodate this Society recommendation.

7. *National Health Service Corps*: A significant aspect of the Congress' rationale for initiating, in 1966, federal-support programs in Allied Health education was its belief that the Allied Health professions could help the health-care delivery systems need to increase services to unserved and underserved areas of the country. Allied Health has since proven its effectiveness in these areas -- Allied Health services are diverse; so are the critical health-care needs in unserved rural and urban areas. Yet the Allied Health professions have been virtually ignored by National Health Services Corps planners.

In 1979, for example, only 28 of 2,379 NHSC scholarships went to Allied

Health students (all 28 were awarded to master's level students in public health nutrition programs). We find it hard to believe that podiatry services, for example, are any more crucial to the health-care needs of underserved populations that the services of audiologists or physical therapists or rehabilitation counselors (106 podiatry students benefitted from NHSC assistance in 1979). The Society asks that the Subcommittee--

> include students in the Allied Health professions among the health professions students qualified for NHSC education assistance and service.

8. National Priority Initiatives: The Society applauds proposals designed by Senators Kennedy and Schweiker to focus special federal support on specified health-care priority needs. We would agree that--

> clinical training, health policy and health-care economics, continuing education, educational costs, curriculum development, and the role of women in health-care education and service are all appropriate areas for special federal funding emphasis. Allied Health training programs should be specified as appropriate recipients of such special funding.

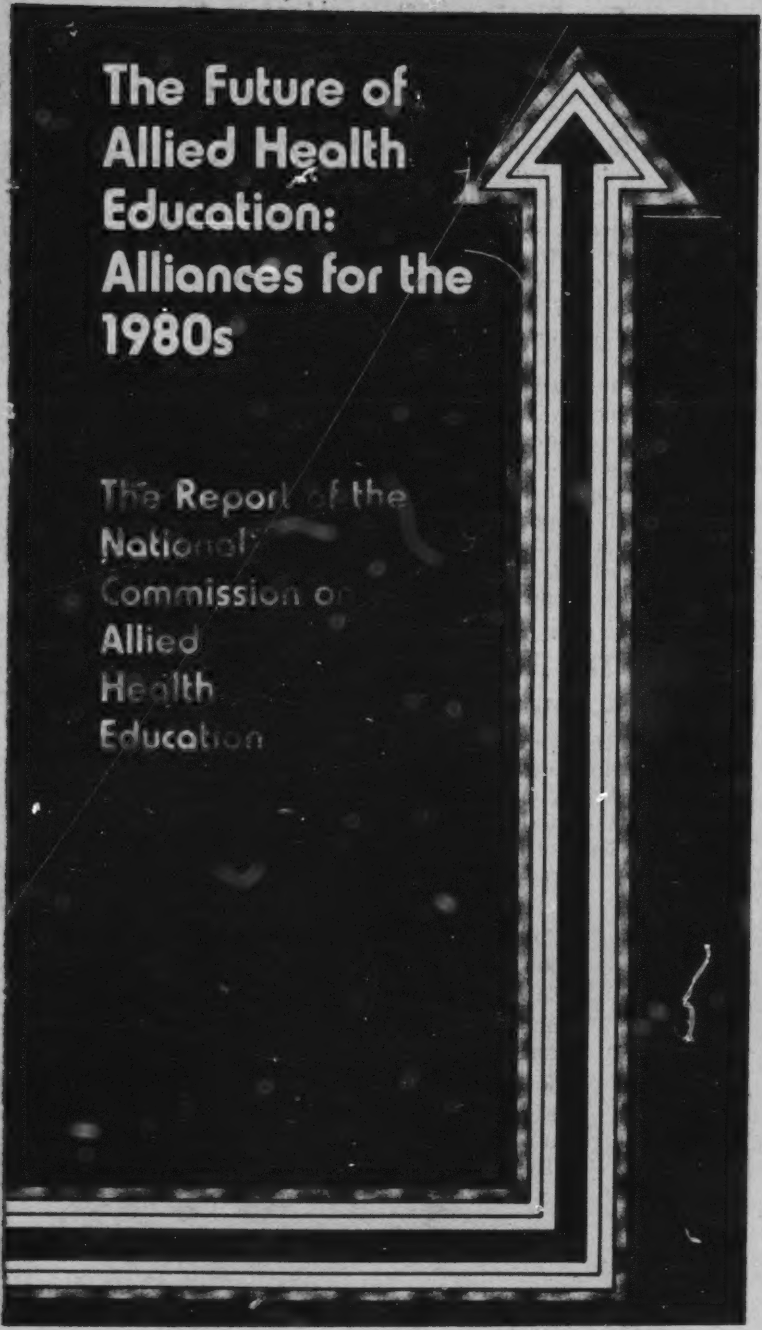
Regarding Senator Kennedy's call for emphasis on the role of women in training and service delivery, we want to suggest that, inasmuch as women comprise approximately 75 percent of the present Allied Health workforce, but occupy only a very small percentage of Allied Health leadership positions, relevant legislative emphases should be on the movement of Allied Health professionals who are women into leadership roles. We also would appreciate a Subcommittee proposal designed to encourage the increased involvement of men in the Allied Health professions.

9. Significant National Allied Health Shortages: The Bureau of Health Manpower has listed the Allied Health professions in which there are (or appear to be) "significant national shortages." We ask the Subcommittee to include in its final measure an amendment to existing section 796 which would--

enable the Bureau of Health Manpower to provide special incentive support to Allied Health education programs which train students in disciplines identified as "significant national shortage" areas, notably audiology, speech pathology, respiratory therapy, dietetics, dietetic technology, physical therapy, occupational therapy, radiation therapy, and dental assisting.

* * * * * * *

The American Society of Allied Health Professions greatly appreciates this opportunity to present its views.



The Future of Allied Health Education: Alliances for the 1980s

The Report of the
National
Commission on
Allied
Health
Education

The National Commission on Allied Health Education

was formed in September 1977 to conduct a two-year study of allied health education in the United States. The Commission was supported by a grant from the W.K. Kellogg Foundation to the American Society of Allied Health Professions (ASAHP), which housed the Commission staff and acted as its fiscal agent. The Commission was independent of ASAHP in conducting its study and formulating its recommendations.

After two years of investigating and evaluating the developments of the last decade, examining current problems confronting the education of allied health personnel, and assessing future health service needs, the Commission developed, on the basis of its findings, a wide range of recommendations which, it hopes, will effectively serve as guidelines for future developments in allied health education.

The Report of the Commission

The Commission findings and recommendations are reported in the forthcoming Jossey-Bass publication *The Future of Allied Health Education: Alliances for the 1980's.* Highlights of this Commission publication include:

- The Concept of Allied Health in the Next Decade: New Meanings and Challenges
- Current Status of Allied Health Occupations and Manpower
- Outlook for Allied Health Careers
- Scope and Diversity of Allied Health Education
- Toward Educational Alliances
- Future Directions: Commission Recommendations and Steps to Achieve Them

Basic Themes Underlying the Commission Recommendations

The Commission recommendations reflect several basic themes:

- Allied health personnel provide essential health care services.
- Formal allied health education is prerequisite to the provision of a competent and sufficient health workforce. Formal education can take place in collegiate as well as noncollegiate institutions.
- The primary purpose of allied health education is to prepare the student for health service. Educational processes must be related to practice needs and viewed as a means for achieving standard performance objectives. The right to practice should be based on achievement of these performance objectives rather than on a receipt of an academic degree. The educational institution—collegiate or noncollegiate — has the responsibility of preparing students to meet these objectives.
- Diversity in educational programs and settings is essential for meeting rapidly changing health service needs. A monolithic approach to allied health education is unrealistic and would result in stagnation. However, wasteful duplication of effort must be avoided through better communication, cooperation, and collaboration.
- The educational process for health occupations should place the interests of the public and the student above special interests of educational institutions and professional groups.

- Information and resource-sharing are essential: There are lessons to be learned from innovations of the past decade.
- The time has come for coordination, collaboration, and cooperation in education and service. There is need for a new spirit to forge alliances and move forward together.

Commission Recommendations

The Commission recommendations address issues and problems in six major areas:

- Alliance
- Determining appropriate content and level of educational programs
- Clinical education
- Building the capability for leadership and innovation
- Planning and administration without waste
- Adequate funding

Fifteen of the recommendations are considered by the Commission to be primary and of equal importance in solving these problems. The Commission also offers 63 procedural recommendations to implement the objectives of its primary recommendations but it recognizes that there are other ways of meeting these goals that may be just as effective.

Primary Recommendations

1. Alliance in service and education should be strengthened based on an appreciation of the interdependence of all health occupations and an understanding of their roles, functions, and special contributions.

2. Education should be linked to practice through role delineations.
3. Allied health education should prepare students who can meet standard performance objectives and adapt to changing health service needs; flexibility in the methods of preparation should be encouraged.
4. To meet new service demands, all allied health educational programs should include the study of (a) human values, (b) illness prevention and health promotion methods, and (c) delivery systems, including roles and functions of health personnel, patients' rights, legal risks, cost-effectiveness, and quality control.
5. In the future, new health service needs should be met, where possible, without establishing new occupations and programs; unnecessary expansion of entry-level requirements should be controlled.
6. The importance of continuing education should be recognized and networks should be established to ensure collaboration and information sharing on continuing education matters.
7. Clinical and didactic education should be better integrated, and the range and types of clinical education sites and methods should be expanded to meet new health service demands.
8. Research in clinical education methods and theory must be greatly expanded.
9. The development of leadership in the clinical, managerial, and educational areas should be a priority for allied health education.
10. Support for research in allied health education should be substantially increased, and allied health faculty should be encouraged to strengthen their commitment to research.

11. Educational institutions should strengthen their efforts to increase the representation of minorities and women in leadership positions.
12. The establishment, expansion, and termination of allied health programs should be based on manpower requirements, adequacy and efficient use of available resources, and collaboration within and among educational and other institutions.
13. Educational and collaborating institutions should adopt mechanisms to facilitate the removal of unnecessary barriers to student progress.
14. Information relating to administration and planning in allied health education should be collected and shared systematically.
15. Significantly increased funding for allied health should be provided at the federal, state, and local government levels and from private resources.

The Future of Allied Health Education: Alliances for the 1980s authored by the National Commission on Allied Health Education will be available early in 1980 from Jossey-Bass Inc., Publishers (433 California Street, San Francisco, CA 94104).

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Senator **Metzenbaum**. Thank you very much, Dr. Holder.

Dr. Filerman, happy to have you with us this morning.

Dr. **Filerman**. Thank you.

I will as an administrator attempt to manage my time efficiently.

I am Gary Filerman, president of AUPHA, a consortium of all of those universities which train administrators of the Nation's health services. This committee, and particularly Senator Richard Schweiker, first gave recognition in public policy to the problem of the management capacity of health services and, as a result, launched an effort to improve health administration education in universities. Simply stated, the purpose of that training is to make the health system work. The problem is clear:

Many of the professions whose training you have been discussing will not be fully productive because of inadequate management in the settings in which they practice;

Geographic distribution improvement is hindered by poorly managed rural and center-city facilities and programs;

Cost containment is a myth if management cannot read a balance sheet or install systems to control the use of expensive resources;

No amount of tinkering with health planning legislation will make an incompetent planning staff effective or respected by providers;

Many existing HMO's are on the verge of failure because of inadequate management. Propping them up with Federal transfusions costs millions of dollars which could be saved by better management, while every failure destroys public confidence in the future of HMO's.

The problem of undermanagement thwarts the efforts of the Congress in virtually every Federal health initiative. Complex organizations, entrusted with lives, billions of public dollars, and careers paid for by the public must be well managed. But the fact is that many are not. The most serious problems are in home health agencies, community health centers, HMO's, rural and urban public general hospitals and nursing homes.

The professionalization of health administration is a fundamental strategy to stimulate efficiency in the system. That is what health administration programs are doing, and this bill is the basis of that strategy. The support started 3 years ago by this committee—and again I must point out Senator Schweiker's dramatic leadership in this area—led to the programs in health administration being more effective in attracting bright young people, increasing the number of programs which provide training and number of graduates, improving the quality of training, providing administrative training to students in other health professions; improving the management skills of people on the job; and providing technical assistance to planning, regulatory and delivery organizations at the community level.

All of the bills recognize the need to improve health management training capacity and its relationship to cost containment. What is needed is to build on the initiative this committee started 3 years ago; capacity building support for the health administration programs which encourages expanded non-Federal support; student assistance which improves competition, particularly with general management and for minority students (95 percent of health service administrators are employed in the public and nonprofit sectors); approaches to exposing graduates to the many managerially underserved health services; an attack on the acute shortage of faculty members competent to respond to expanding demands for teaching, technical assistance and systems improvement research; and a systematic appraisal of management methods developed in other sectors which hold promise of improving the efficiency of health services.

Mr. Chairman, the universities look forward to working with the committee in this effort, which is so fundamental to the success of so many other health initiatives. We would appreciate having our detailed comments on the several bills entered into the record. Thank you.

Senator **Metzenbaum**. All of the statements of all the witnesses will be included in full in the record this morning.

[The prepared statement of Dr. Filerman follows:]

AUPHA
[illegible]
[illegible]

STATEMENT

ON

S. 2375, S. 2378, S. 2144

GARY L. FILERMAN, Ph.D.
PRESIDENT

MARCH 12, 1980

Mr. Chairman and Members of the Committee,

I am Gary L. Filerman, President of AUPHA, a consortium of 116 colleges and universities involved in health services administration education. The mission of this public service corporation demonstrates the growing demand for the nation's educational resources to respond to the vast management training requirements of health services. AUPHA brings together graduate and undergraduate schools and programs based in schools of medicine, public health, business administration, public administration and allied health in one coalition effort to focus scarce resources on a critical issue which permeates the health system at all levels, in all communities and all institutions. That problem is the shortage of personnel who are competent to manage the most complex, expensive and necessary of community services.

The Problem

Health services administrators live with the results of the work of this Committee. They deal every day with problems of specialist availability, nursing shortages, roles of new professions, personnel costs and practitioner competence. Every aspect of health manpower policy affects their work, and they have a significant influence upon the success or failure of that policy. Good management can make better use of scarce resources. An effective administrator creates the conditions under which health professionals are optimally productive by assembling resources, arranging appropriate staffing and making sure that quality control systems function properly. Effective administrators assess community needs, guide institutions and programs to respond and help communities understand the needs and roles of health services. They make sure that the community's investment in people, facilities and equipment is protected. They bring professional skills, standards and commitment to planning, rate setting, quality assurance and the development of new services. Such professional management skills are essential to the delivery of quality health services on an equitable and cost-effective basis.

The fact is, however, that management competence in health services is grossly uneven and the problem is growing. There are few management responsibilities which offer a greater opportunity to directly affect the quality of community life. But the demands of the position are extraordinary. Public accountability means management must respond to the information requirements and management regulations of many public agencies, which limit managerial options. The problem of securing support by appropriation, reimbursement, charges, borrowing, or contributions is dwarfed by the challenge of working with labor unions, medical societies, accrediting organizations and community interest groups.

The problem of undermanagement in health organizations has been overlooked for years because of two reasons. First was the assumption, now disproved, that producing more practitioners of all kinds would solve problems of service availability. The second reason is that the most conspicuous health service is the community general hospital, which commands the best management resources in the system. Many federal initiatives to meet health service needs, either directly or indirectly, have limited success because they outrun the management available to them. Pumping more money into the health system without better management technology is like putting billions into the space program without first developing the basic technology needed.

There are not enough appropriately-trained administrators. In addition, some regulations limit the investment which can be made in management. There are serious management shortages in HMO's. Emergency medical systems, nursing homes, home health agencies, community health centers and urban and rural general hospitals. The Labor Department has identified administration as the health career with the largest unmet need in the next decade. The result is that:

- Many of the health professionals whose training you have been discussing in these hearings will not be fully productive because of inadequate management of the settings in which they practice.
- Geographic distribution will continue to be hindered by poorly managed rural and center city facilities and programs.
- Cost containment efforts will have limited effectiveness because of the inability of managers to install systems to control the use of expensive resources, to deal with the information which they produce, and to interpret it effectively to providers and to the community.

* No amount of tinkering with health planning legislation will make an incompetent planning staff effective or respected by providers and the community.

* Many existing HMO's are on the verge of failure because of inadequate management. Propping them up with federal transfusions costs millions of dollars which could be saved by better management, while every failure reduces public confidence in the future of HMO's.

This is cost-containment legislation of the most fundamental and far-reaching kind.

Legislative History

This Committee, and Senator Richard Schweiker in particular, has written the brief legislative history of federal efforts to solve the management capacity problem. PL 94-484 provided the first support to specifically improve and expand health services administration programs in universities. Previous health manpower legislation provided support to schools of public health, but it was not earmarked for their administration components. Programs in other settings, that is the most programs with the most graduates, were eligible only for competitive project grant funds which were spread over many fields, with the result that relatively few programs received improvement assistance.

PL 94-484 provided grants to build the service capacity of accredited graduate programs outside of the schools of public health. The grants were well targeted to improve the program's effectiveness by requiring a floor of nonfederal support, a minimum class size, increased enrollment and accreditation. The programs were also provided with a modest amount of traineeship support intended to increase their ability to serve people with experience in health work, attract minority group members and compete for unusually strong talent.

Under 94-484, the programs based in schools of public health continued to be included in the general support of the schools. Traineeships were allocated through the school. Project grant support was available from the same general pool of competitive funds to which literally hundreds of public health related programs have access.

About a third of the programs in health administration are based in schools of public health. Therefore, general support to schools of public health is very important to the improvement of management training capacity.

Because of forward funding, the graduate programs in health services are now completing only the second year of federal support. There has already been substantial progress toward accomplishing the objectives of the federal support.

The principal objective of PL 94-484 was the establishment of a national network of university based health administration training centers which are capable of:

- o Attracting and providing quality education for an expanded number of professional health administrators;
- o Providing continuing education to improve the knowledge and skills of administrators and planners throughout the system;
- o Contributin administrative and health systems content to the education of other health professionals;
- o Providing technical assistance to delivery, regulatory, financing and planning agencies in their service areas; and
- o Conducting needed health services research.

The Record

As a direct result of the health services administration sections of PL 94-484;

- o The number of students graduating from accredited graduate programs outside of schools of public health has increased from 720 in June, 1977, to 822 in June, 1979, a 14.2% increase.
- o The number of accredited graduate programs has increased from 21 in 1977 (June) to 25 in 1979.
- o The level of nonfederal support for several programs has been increased significantly.

- Continuing education and technical assistance activities have increased substantially, especially focusing upon cost containment, strategic planning, financial management and labor relations.
- Graduate faculties have increased in numbers, thereby expanding capacity for service.

The effort to improve training capacity for management under PL 94-484 is beginning to pay off. It is already a cost-effective public investment and will be more so if continued.

The federal government must stimulate greater efficiency in the health system. The professionalization of health services management, including planning and regulation, is a fundamental strategy for improved efficiency. There has been substantial progress in improving professional education, a foundation of professionalism.

What is Needed

Programs in health services administration are essential resources in the effort to improve the efficacy of health services. Every dollar invested will pay short and long term dividends if the programs develop and sustain the necessary critical mass of skills. Present programs are small--they frequently have only five or six staff members. Before PL 94-484, these programs had a staff of only three or four professionals.

The larger size makes it possible to add specialists in such critical fields as finance, long-term care, HMO management and continuing education. Therefore, there is a direct relationship between the number of students enrolled and the size of the faculty; between scope of services offered to the community and program "critical mass". The support under PL 94-484 had direct and effective impact on that balance. Therefore we recommend that support to develop the basic capacity of health administration programs be continued for three years.

The targeting of this support can be focused to guide the programs toward optimal response to public policy priorities. The required nonfederal first-dollar support is a good example. Several of the programs are now on a firmer support base as a result.

The enrollment increase requirement has been a definite factor contributing to a 14% increase in graduates from eligible programs over the past three years.

Accreditation assures a minimum core of content and orderly assembly of resources across all settings where programs are based. Programs based in medicine, public health, business administration, public administration and other settings have a common frame of reference. That framework is the product of a fully recognized accrediting agency composed of: The American Hospital Association, The American Public Health Association, The American College of Hospital Administrators, The American College of Medical Group Administrators, The American College of Nursing Home Administrators, The American Health Planning Association, The Association of Mental Health, The Association of University Programs in Health Administration. The purpose of providing support to students to train in health management are:

1) It is essential that health administration successfully compete for the most well-prepared and motivated young people. The field does not now receive its share of talent which the public responsibility for health services management requires.
2) The programs need to sustain their ability to attract experienced health workers. The average age of 1979 graduates was 29.3, indicating the appeal of graduate education in this field for mature students. Such average also indicates that many have family obligations which would keep them from school if traineeships were not available.
3) The most consequential role for a minority group member in health is in the management and planning of community health services. The 13% minority graduation rate in 1979 demonstrates the ability of the programs to attract minority students and demonstrates the need for effective, flexible student aid. Therefore we recommend:

   A system of traineeship support designed to improve the recruitment of potentially excellent administrators, and which gives the programs the flexibility to assist each student in the most effective way, commensurate with national priorities.

The most stable characteristic of health service management is change. The programs must develop individuals who are prepared to manage organization change. A "change agent" in the best sense commands skills which are basic to management of large complex organizations, understands the forces which dictate change and has professional objectives of public service which give direction to his efforts. The programs must assess the change process in the real world, project developments and revise curricula, ideally to be ahead--to be training for tomorrow as well as today.

Grants for special projects facilitate adapting to changing needs. Programs need to develop new curriculum materials for the management of cost containment, control of growth and resource scarcity. Multi-unit systems and shared services require new management skills, which are being identified by studying such organizations in health and in industry. Revising curriculum, organizing specialty tracks and developing new continuing education offerings are major projects which must be supported if health administration training is to keep up with the demands of the system.

Project grants are on effective change strategy because they can be targeted to national priority needs. They also require well-developed, competitive applications for which a program must organize resources and provide basic data necessary for an effective implementation plan and evaluation process. They are necessarily "stop-and-go" stimuli and very different from capacity development grants which are designed to encourage organizational stability. To use public funds well, projects should have specific end points at which developmental work is integrated into the ongoing program, freeing project funds for further "cutting edge" activities. Therefore, what is needed is:

Provision for grants which facilitate change, adaptation and innovation in health administration education, and which encourage response to national priorities and quality through peer review.

Capacity development, student support and special project grants are the most cost-effective and potent means to realize the potential of an improved health services administration system. However, the amount of dollars which the existing and new programs can put to effective use is limited because of the acute shortage of appropriately-trained faculty members.

Carefully planned faculty development effort will meet the needs of the programs as their capacity expands. Only two or three years before this Committee began the effort to improve management training capacity, the production of faculty practically dried up. Additional well-trained faculty are needed to carry forward our health services instruction, research and system improvement agendas.

The principal sources of doctoral level talent were programs sponsored by the National Center for Health Services Research and the W.K. Kellogg Foundation. Those programs have ended. There is now very little doctoral training specifically geared to health

health services administration. Individuals with a doctoral degree in a discipline basic to health services, such as economics, political science, sociology, operations research, finance or organizational behavior need substantial orientation to the health applications of their fields before they can effectively contribute. The same applies to such key specialists as lawyers and C.P.A.'s. On the other hand, physicians, dentists and other health specialists lack disciplines which provide broader perspectives and analytic skills. There is no system in place for meeting the current and expanding need for doctoral-level health administration program and faculty leadership. Programmatic or fellowship support for faculty development is an essential element of improving the management training system.

Legislative Options

The fact that all four of the bills before the committee emphasize the critical role of health administration education should be a source of satisfaction to this Committee. Furthermore, all of the bills maintain or expand current levels of investment, demonstrating an important concensus.

We find strengths in all of the bills. However, the administration bill places all support, of all kinds, in one project grant authority for public health and health administration. By doing so, all focusing of this investment by the Congress is removed. On the basis of previous experience, health administration training resources should be carefully allocated by the Congress to prevent diversion to marginal activities or pet projects. Articulation with the needs of federal provider efforts, such as HMO and health planning development or cost containment efforts, is best done by the Congress through earmarking. The administration bill does not make such articulation likely. We are pleased, however, that the suggested authorization level is at least as high as the 1981 budget projection for public health and health administration, excluding public health school capitation. The bill is grossly deficient, and totally disregards national priorities for strengthening health prevention and management services by not providing public health school core support. If public health schools are weakened by a further reduction of federal support, all programs in health administration will be weakened because the schools train many of the faculty for all programs, conduct a significant portion of all health services research and, in fact, produce about 35% of the graduates in this field.

S.2375

S.2375 is a strong bill with a great deal to commend it as an overall approach to health manpower development. The bill integrates health services administration student support into broader armamentarium which could serve the needs of this field adequately. It should be noted that AUPHA has for several years supported the concept of service "payback", particularly when it exposes graduates to federally supported delivery programs which are "managerially underserved".

Section 798 provides for continuity of core support for eligible programs, with a reasonable increase in the nonfederal support required. It also requires a specific commitment to "cost-efficiency" curriculum development which is appropriate in our judgment.

Section 799 provides project grants to both accredited schools of public health and graduate programs in health administration. The section lists six areas for expansion of new programs. We believe that a separate project authority for accredited health administration programs and those in accredited schools of public health would more effectively meet the objective of strengthening management training capacity. This would permit allocation or priority setting within the general health administration area as well as more effective evaluation of programmatic initiative. Since a major need in the field is further development of the skills and knowledge of incumbent administrators, the emphasis on continuing and part-time education in Section 799 is very timely. Again, however the possibility is great that this thrust will receive a low priority in competition with educational approaches and public health activities which have been the traditional interests of HEW.

S.2144

S. 2144 continues Senator Schweiker's outstanding record of interest and leadership in dealing with the problem of the management capacity in health services delivery systems. We are pleased that within the overall approach of the bill, health administration is recognized as a key field for future development. We have serious reservations about discontinuing capacity development core support prematurely and replacing it with a project grant authority. There appears to be a strong consensus on continuing support for the development of this field which would not preclude continuing the modest amount of core support needed for three more years. The current effort has demonstrated its effectiveness in a field where there is no overproduction, as was anticipated by Senator Schweiker three years ago.

The problem with a broadly phrased project grant authority has been described with reference to S.2375. It is the lack of articulation with health initiatives and policies which are outside of the manpower area, and frequently not the primary concerns of the managers of manpower authority. If a general project grant approach should emerge as the vehicle for health manpower policy implementation, S.2144 is far more responsive to the needs of the health administration field than is the Administration bill. Again, we would suggest dividing the public health and health administration authorities to tighten targeting, planning and evaluation of the management development effort.

Another strength of the bill is the provision of traineeships. However, we are not clear how an allocation between project and traineeship support would be made and believe that different criteria and priorities apply to each. We suggest therefore a further allocation between project and traineeship support provisions. The general student aid provision in S.2144 is also appropriate for health administration students. There are many managerially underserved regions and services wherein public service could make a real contribution far outrunning the value of the loans forgiven in the process. Further, this feature will expose graduates to practice sites which may become real career interests. It should be noted that 95% of health administration graduates work in the public sector, which merits consideration in setting interest rates.

Let us reiterate that our fundamental concerns with S.2144 are the premises that there is an overproduction of manpower and that all forms of institutional support must be terminated. Support which stimulates expansion of quality settings is still required to meet very urgent needs in health management. The modest level of "institutional support" now being provided, money which is not "first dollar", remains a solid investment of public funds. Should the premises of S.2144 prevail, it would be strengthening by adjustment to more clearly distinguish the health administration and public health components and to use accreditation to assure minimum quality in both cases.

S.2378

Mr. Chairman, Title One of S.2378 maps a particularly well conceived effort to improve the management of health services. The bill clearly builds upon the foundations developed by Senator Schweiker, and we hope that he and Senator Javits will work together to accomplish their common objectives. The successive work of these Senators is welcomed by every community board, health agency head, voluntary health organization and health administration training institution.

S.2378 is a systemwide strategy which includes improving entry level education; expanding capacity for entry level and continuing education as well as technical assistance; developing management for managerially underserved health services; strengthening management development by nonprofit organizations and assessing needs and untapped technologies. The "bottom line" is that the practice of management at the community level would be impacted directly and in several ways, including long range, lasting improvements. This is a cost containment bill which is limited in effectiveness only by the fact that the effort is so new, and the intervention points so undernourished that a greater investment cannot be well used.

S.2378 would provide support to attract needy and talented personnel to the field through fellowships. Each fellowship would have a built-in "pay back" provision, including support for the two year graduate education followed by support for a year of university supervised service in a managerially underserved health activity. This approach is designed to give program graduates a chance to experience work in facilities and services which now receive few, if any, professional health services administrators. Such facilities usually lack sufficient funds to bring in young administrators, so program graduates are naturally attracted elsewhere.

There is a tight logic to the focus of the fellowships, requirements for capacity development support and project grants. For example, one specialized fellowship site is HMO's under section 1301. One of the areas of concentration which a program may have to qualify for program support is ambulatory services and one of the priority special project areas is ambulatory services management. Thus, a major problem is treated consistently from several directions.

Minority enrollment efforts are encouraged by specifying minimum representation to quality for federal support. This field has a good record in recruiting minority students, primarily through support for special efforts from HEW, the W.K. Kellogg and Robert Wood Johnson Foundations, and the American Hospital Association. Even with our success and this array of support, we can do a better job. The levels suggested in the bill are generally realistic and will require renewed effort. There is a need, however, for the addition of a waiver provision to accommodate situations where all our efforts do not succeed.

Curricular response to national priority issues is assured by specification that the programs provide a mix of courses from among several important ones listed. There is a high degree of concensus in education and practice about the need for all of the topics required.

The requirement will stimulate programs to fill out their present offerings. This applies equally to the requirement for the provision of fields of concentration.

The existing project grant authority is adjusted to remove accredited programs in all settings from eligibility, but continues eligibility for health administration programs in accredited public health schools. A new and well focused project grant authority is added, designed to build upon the strengths of accredited programs in all settings. The curricular areas targeted for improvement reflect the same areas identified by AUPHA, the Accrediting Commission on Education for Health Services Administration (ACEHSA), and the field in general. An investment in the development of these topics will yield substantial gains in program effectiveness.

We have said many times that this field cannot use very much more support well. The reason is that there is a marked shortage of faculty who are qualified to respond to the growing education, service and research demands of health services. Part of the problem in drawing upon individuals without integrated health services training was outlined earlier. Another problem is the long production lead time and the attendant cost. It takes two to four years of post-Master's work to produce a Ph.D. in health services. The programs could absorb more than 25 newly trained Ph.D.'s today, but we do not have them.

S.2378 provides a creative, cost-effective, moderate-priced solution to our problem. It also helps solve the problem of underemployment of faculty in some disciplines which are affected by decreasing university enrollments. It will involve not only Ph.D.'s but C.P.A.'s, L.L.B.'s, M.D.'s, etc. The bill provides modest ($1 million) support to accredited programs to give individuals well trained in basic fields a one-year health services experience. They will come on the program job market, well prepared, in a short time and at a low cost. This is imaginative and timely and should be supported because it will strengthen all management oriented training efforts.

The bill recognizes that it is possible to improve present management practice by establishing a specific authority for the purpose. Sec. 799 is designed to mobilize and strengthen a broad range of underutilized resources in the management improvement effort. These include national state and local organizations which have front line, day to day contact with physicians, facilities, official and voluntary agencies and others who can benefit from management training which is up to date, immediately relevant and accessible. This authority will provide the front-end support to develop programs to meet this need. Many of these efforts will then become self-supporting.

Finally, Mr. Chairman, S.2378 mandates a long overdue evaluation of and game plan for development of health management. The report approaches the problem from the management perspective, recognizing this country's great management achievements and attempting to focus that experience on the health sector. We think that documentation of the problem will do a great deal to sharpen both public and private efforts to improve productivity. Clear guidelines for future public policy should result.

The report will be particularly valuable in developing and improving federal health initiatives because it will systematically explore their impact on management effectiveness. Today we are faced with conflicting claims involving cost, accountability, and complexity. Perhaps with this study, implementation can be designed to enhance management's contribution rather than hinder it.

The universities and professional bodies in health administration and planning are anxious to contribute to the full range of important initiatives outlined in this bill and look forward to working with the Committee to that end.

Thank you.

APPENDIX A

NUMBER OF ELLIGIBLE ACCREDITED PROGRAMS

As of 7-1-79	25 programs
As of 7-1-78	23 programs
As of 7-1-77	21 programs

NUMBER OF GRADUATING STUDENTS FROM ELLIGIBLE ACCREDITED PROGRAMS

1979	822 individuals
1978	749 individuals
1977	720 individuals

The number of graduating students increased by 4.03% between 1977 and 1978 and 9.75% between 1978 and 1979. The increase in graduating students between 1977 and 1979 was 14.17%.

APPENDIX B

ACCREDITED MASTER'S PROGRAMS IN HEALTH SERVICES ADMINISTRATION IN NON-SCHOOL OF PUBLIC HEALTH SETTINGS

GEOGRAPHIC LOCATIONS

ALABAMA

University of Alabama-Birmingham

ARIZONA

Arizona State University

COLORADO

University of Colorado

DISTRICT OF COLUMBIA

The George Washington University

GEORGIA

Georgia State University

ILLINOIS

University of Chicago
Governors State University
Northwestern University

IOWA

University of Iowa

MASSACHUSETTS

Boston University

MISSOURI

University of Missouri-Columbia
Saint Louis University
Washington University

NEW YORK

City University of New York
Cornell University

OHIO

The Ohio State University
Xavier University

Appendix B

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Accredited Master's Programs in Health Services Administration
in Non-School of Public Health Settings

PENNSYLVANIA

Pennsylvania State University
University of Pennsylvania
Temple University

TEXAS

Trinity University

VIRGINIA

Medical College of Virginia, Virginia Commonwealth University

WISCONSIN

University of Wisconsin-Madison

APPENDIX C:

MASTER'S DEGREE PROGRAMS IN HEALTH SERVICES ADMINISTRATION WHICH WILL APPLY FOR ACCREDITATION DURING 1980-1983

GEOGRAPHIC LOCATIONS

CALIFORNIA

California State University-Northridge
Golden Gate University
University of Southern California

DISTRICT OF COLUMBIA

Howard University

FLORIDA

Florida International University
University of Florida
University of Miami

INDIANA

Indiana University

KANSAS

University of Kansas

MISSISSIPPI

University of Mississippi

NEW YORK

Long Island University-C.W. Post College
New York University
Union College

OHIO

University of Cincinnati

TENNESSEE

Meharry Medical College

TEXAS

University of Dallas
University of Houston-Clear Lake City
Texas Women's University

1979 SURVEY OF HEALTH ADMINISTRATION STUDENTS' FIRST POSTGRADUATE EMPLOYMENT

APPENDIX D

The 1979 survey reports information regarding postgraduate employment for students completing their degrees in 1979. The response rate was 68.4%, representing 1013 of the 1481 individuals contacted.

1. In your position:

98.6%	Full-time employment (35 hours per week or more)
1.4%	Part-time employment (less than 35 hours per week)

2. Specify the type of community in which you are employed:

50.5%	Large city (population 500,000 or more)
11.7%	Suburb of large city
23.1%	Moderate size city (population 50,000 to 500,000)
1.1%	Suburb of a moderate size city
8.9%	Small city (population 10,000 to 50,000)
3.0%	Town (population 2,500 to 10,000)
.7%	Small town (population less than 2,500)
.8%	Rural/unincorporated area.

3. Was this position your first choice (for example, did you accept a consulting position when you would have actually preferred a hospital administrator job?)

76.4%	Yes, the position was my first choice.
23.6%	No, the position was not my first choice.

4. Indicate from the following list the type of agency or institutional setting in which you have accepted employment:

37.2%	PUBLIC SECTOR INSTITUTIONS/AGENCIES	
	14.2%	Public hospital (city, county, state, university)
	1.9%	HEW
	2.9%	Health systems agency or other planning agency
	.4%	International agency/institution
	1.7%	Mental health or retardation facility
	5.7%	Military facility
	.8%	Regulatory agency
	3.1%	State or local health department
	2.3%	VA facility
	4.2%	Other governmental agency

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AUPHA
1979 Survey of Health Administration Students' First Postgraduate Employment

47.6%		COMMUNITY SECTOR INSTITUTIONS/AGENCIES
	31.1%	Community, general, or private university hospital
	3.5%	Associations, foundations or voluntary agencies (AHA, AMA, Heart Fund, etc.)
	1.0%	Blue Cross-Blue Shield or other prepayment plan
	.6%	Home health agency
	2.5%	HMO
	1.7%	Not-for-profit clinic or community health center
	.6%	Not-for-profit long-term care facility
	1.0%	PSRO
	2.0%	Research, teaching, university administration
	3.6%	Other community sector facility
15.3%		FOR-PROFIT INSTITUTIONS/AGENCIES
	5.1%	Investor-owned hospital
	1.0%	Clinic (for-profit)
	6.7%	Consulting firm
	.6%	Long-term care facility (for-profit)
	1.9%	Other for-profit facility

5. If your position's major operating responsibilities fall into any of the following national priority areas, circle all that apply:

8.8%	Development or management of a pre-paid group practice plan.
28.3%	Development or management or other ambulatory care programs.
21.6%	Financial analysis and feasibility studies for hospitals, multi-institutional or regional health planning systems.
9.2%	Health promotion and disease prevention.
10.0%	Information systems development/maintenance.
6.6%	Management of cost containment programs.
2.2%	Member of governmental regulatory agency (Federal, state, or local level).
10.4%	Other planning functions.
2.9%	Quality assurance.

6. From what source(s) did you obtain funds for meeting educational expenses during your graduate education?

Primary Source	Secondary Source	Source of Support Categories
17.7%	5.2%	Full-time job during academic year.
7.8%	28.3%	Part-time job during academic year.
22.9%	12.9%	Immediate family or relatives (including working spouse).
18.6%	15.0%	Loan(s).
9.9%	18.2%	Personal savings and/or unearned income.
3.8%	3.4%	Subsidation by employer.

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AUPHA
1979 Survey of Health Administration Students' First Postgraduate Employment

Primary Source	Secondary Source	Source of Support Categories (Q 6 continued)
13.5%	11.2%	Traineeship, fellowship, scholarship, grant.
2.7%	3.5%	Veterans' educational benefits.
3.0%	2.3%	Other

7. Sex: 60.4% MALE 39.6% FEMALE

8. Race/ethnic background:

7.8%	Black, not of Hispanic origin
1.2%	American Indian or Alaskan native
87.0%	White, not of Hispanic origin
2.1%	Asian or Pacific Islander
	Hispanic:
.5%	Mexican American/Chicano
----	Puerto Rican (Mainland)
.7%	Puerto Rican (Commonwealth)
.7%	Other Hispanic

Senator **Metzenbaum**. I just have a couple of questions.

Anyone or all of you can respond.

What is your reaction to the administration's proposal pertaining to public health, health administration and allied health?

Dr. **Holder**. Senator, the administration's proposal would be a disaster. It would eliminate allied health from the scene and, as both educator and one involved with the American Society of Allied Health Professions, it would decimate us.

Senator **Metzenbaum**. Mr. Gemmell?

Mr. **Gemmell**. Mr. Chairman, we are puzzled as to why the administration is eliminating special support to school public health and graduate programs of health administration since, in its own report, "Healthy People," and a recent Bureau of Health Manpower Report, stress the need to train more people in these areas. We are puzzled why they should eliminate specific categories and combine them into a general authority if public health is so crucial.

We appreciate the fact we are mentioned, but we do decry the fact that our basic general support is being eliminated.

Dr. **Filerman**. I would only add one comment; that is, to point out the gross inconsistency between constantly pounding on the door of Congress for cost containment legislation and failing to fund fundamental training efforts that provide cost containment capacity and management. That just simply will not work, and complex requirements, complex legislation cannot be implemented by individuals who are not able to handle complex systems.

Senator **Javits**. Would you yield to me?

Senator **Metzenbaum**. Certainly. Happy to have you with us this morning.

Senator **Javits**. Mr. Chairman, I would like to thank Dr. Filerman and his associates for the kind words they have said about my bill, and to assure them that I will work closely with Senator Schweiker and the other members of this committee on any concerns they might have about the legislation.

Senator METZENBAUM. Thank you, Senator Javits. I appreciate your leadership role in this entire area.

I have one additional question.

I have been working on a piece of legislation with American College of Preventive Medicine that would supply funding for training of physicians, nurses, public health professionals and allied health workers in the public service area and occupational health.

How do you feel about such an emphasis in health professions legislation?

Mr. GEMMELL. Mr. Chairman, long needed.

One of the critical areas of need in the last couple of years, because of all the environmental health laws, industry and government sector or public sector, need more trained individuals and occupational and safety and health, environmental toxicologists and industrial hygienists. The problem is that there is a lack of funds in these areas.

There has always been Federal money, for the last 10 years, for this type of training but it has remained constant, but at the same time, Federal initiatives have increased and demand for health manpower in environmental health; and this is one area where there is a great demand. We applaud your leadership efforts in this area and will work with our colleagues in the American College of Preventive Medicine to see that your bill is enacted.

Senator METZENBAUM. Thank you.

Senator Schweiker?

Senator SCHWEIKER. Thank you.

Dr. Filerman, how many programs in health administration are there now?

Dr. FILERMAN. Well, in terms of nonpublic health programs, that would be eligible under these various items of legislation, about 25 at the current time, and another 10 to 14 preparing for accreditation over the next 3 or 4 years.

In addition, all schools of public health contribute significantly to health administration training.

Senator SCHWEIKER. How many graduates would be turned out in this specific area this year, just approximately?

Dr. FILERMAN. Again, I would say in nonpublic health settings, roughly 1,000, and an additional 600 or so in public health.

Senator SCHWEIKER. What is the demand for these graduates?

Dr. FILERMAN. It is a field in which nobody looks very long for a job. We did a study of 1979 graduates, and something like 75 percent of them got jobs of their first choice. That indicates a pretty strong market.

When you look at very large components of delivery systems in which there are virtually no trained administrators, long-term health, home health agencies, and so on, demand is unlimited, Senator.

Senator SCHWEIKER. It is just astounding to me that the administration would even consider eliminating support in this area in view, as several of you mentioned, of the cost-containment problem and the growing obvious explosion of the health care delivery system. It is just unbelievable to me that they come in with that recommendation. Of course, I think the committee will not be sympathetic to that at all.

Senator **Metzenbaum**. I would like to associate myself with the Senator's remarks. To me, it is incomprehensible how there would be a withdrawing of support in the field of medical administration. I agree with your whole statement and Senator Schweiker's comment.

Senator **Schweiker**. Just one more question, Doctor Filerman.

What kind of continuing education or similar part-time programs, do you have to supplement the impact of your schools, if any?

Dr. **Filerman**. There is a large number of this going on. I will give you a dramatic example.

We have a program in Cincinnati that is teaching health administration in Appalachia by satellite to people on the job. We have a program in Minnesota that is offering a masters degree to people on the job. They have got students in practically every State now. There is a great deal of outreach in that respect.

That hones in on the highest need; that is, really upgrading people on the job. We know in terms of this job market that we can double the number of graduates tomorrow, and we would have relatively little impact on people already out there. So we need those outreach programs.

The problem is that in a tight money situation, they are the first thing you cut back. They reach the lowest number of people per dollar invested. They also probably have the highest return on the investment. That is the dilemma. There is a lot of interest in it.

What you did in your bill last year was the primary stimulant for development in this area.

Dr. **Holder**. May I add a comment?

I have not seen in existing bills a provision, or what I consider to be adequate provision, for some of the more nontraditional programs that get at the people who cannot afford to matriculate in the school of public health on a full-time basis. I am speaking of programs, if you will pardon a personal example, between the University of Tennessee and Memphis State University that is linked with public administration. We have students who, because of economic considerations, cannot go away to school—they have full-time jobs and are able to pursue a program in health administration while on the job in late afternoon and evening. In present legislation, there is no Federal support for these programs. I would ask that such be considered because you have a lot of people who are in midcareer levels and need to be upgraded and want to.

Senator **Schweiker**. Dr. Holder, I think it is a suggestion worth considering. I think that is a very good idea.

Your statement, Dr. Holder, recommends allied health projects involving cost containment, underserved areas, meeting new health service needs without creating new specialties, and curriculum development.

My bill authorizes these kinds of projects.

Where do you think the emphasis would be with this kind of support?

Dr. **Holder**. With past very modest Federal support, I can give you a few examples of programs that have been started that address some of these questions. I am thinking of the Center for Interdisciplinary Education in Allied Health in Kentucky, in which they are training people to go into under-served areas as teams to analyze a community's health service needs, and so forth. I am thinking of the linkage program at the University of Alabama which links community colleges and facilities with the academic health sciences center and clinical facilities in Birmingham.

We have the American Society of Allied Health Professions standing Committee on Equal Representation in Allied Health, which is working on programs to identify Allied Health professionals among minority groups, and data are virtually nonexistent in this area.

There are a number of these programs and projects that universities and professional organizations could carry out. They are doing it on a modest scale now, but we simply do not have the kinds of funds to allow us to run our basic programs and undertake these very important other initiatives.

Senator **Metzenbaum**. Thank you very much, Senator Schweiker.

I want to thank the panel. They have been extremely helpful to us. I think your comments will have an impact on the legislative process.

Dr. **Filerman**. Thank you.

Senator **Metzenbaum**. Our next panel consists of Hazle Blakeney, chairperson, department of career development program, school of nursing, University of Maryland, representing the American Nurses' Association; Carolyne K. Davis, associate vice-president for academic affairs, University of Michigan, representing the National League for Nursing; Rose M. Chioni, dean, school of nursing, University of Virginia, president of the American Association of Colleges of Nursing, and representing the American Association of Colleges of Nursing; Russell Perry, a student from Trenton State College, representing the National Student Nurses Association; and Louise W. Esiason, Castleton State College, Castleton, Vt., representing the Federation of Nurses and Health Professional/American Federation of Teachers, AFL-CIO.

We welcome all of you here this morning.

STATEMENTS OF HAZLE BLAKENEY, ED. D., CHAIRPERSON, DEPARTMENT OF CAREER DEVELOPMENT PROGRAM, SCHOOL OF NURSING, UNIVERSITY OF MARYLAND; CAROLYNE K. DAVIS, PH. D., ASSOCIATE VICE PRESIDENT FOR ACADEMIC AFFAIRS, UNIVERSITY OF MICHIGAN; ROSE M. CHIONI, PH. D., R.N., F.A.A.N., DEAN, SCHOOL OF NURSING, UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE, AND PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING; RUSSELL PERRY, STUDENT, TRENTON STATE COLLEGE; AND LOUISE W. ESIASON, R.N., M.A., CASTLETON STATE COLLEGE, CASTLETON, VT., A PANEL

Dr. **Blakeney**. Mr. Chairman, we would like to comment briefly and ask that our full statements be included in the record.

Senator **Metzenbaum**. It certainly will be.

Dr. **Blakeney**. To avoid repetition, I will focus on the nurse supply and trends issues, and my colleagues will talk about some of our other concerns.

First, we would like to thank the members of this committee for their concern for nursing education and for the very thoughtful and carefully constructed bills which have been introduced to provide Federal support to nursing schools and students.

We support S. 2375 and several sections of S. 2144.

We understand the need for budget restraints and the need to evaluate program cost effectiveness, but I would submit that this is the only program--or certainly one of a very few--that undergoes sunset review every year.

We are discouraged by the administration's inability or unwillingness to acknowledge the changing nursing role in health care and the increasing demand for nurses and, to recommend the kind of assistance that is needed to strengthen nursing's efforts to provide adequate nursing service now and in the future.

The Secretary of the Department of Health, Education and Welfare states flatly that there is an adequate supply of nurses and that the only problem is "to keep a higher proportion * * * actively in the profession."

We would agree that the shortages are not only a matter of numbers. The problem is much more complex.

However, it is not just a problem of retaining nurses in the profession. According to our nationwide sample survey, there are some 1.4 million RN's who hold current licenses to practice. Of those, over 70 percent are employed in nursing. This is considered a very high proportion. It is much higher than the labor force participation rate for all work-eligible women, which is about 56 percent. For those women who are college graduates, the figure is 61 percent.

Of the less than 30 percent of nurses who are not employed in nursing, the survey found only about 62,000 to be working in another field; more than 42,000 had children under 6 years of age; 42,000 were seeking employment, and about 104,000 were over 60 years of age.

While there has been a large increase in the supply of nurses in recent years, they also are being absorbed into the work force at a high rate.

About 601,000 nurses work in hospitals, an increase of nearly 16 percent since 1972. Nearly 80,000 RN's work in nursing homes and extended care facilities, a 42-percent increase over 1972, when the last previous survey of nurses was conducted.

Senator Schweiker has referred to causes for the shortages of nurses, and we look forward to participating in the Institute of Medicine study which we believe will give us some systematic and reliable data about the nature and the problems and trends in nursing. That study was authorized through the Nurse Training Act and it has not yet been funded by HEW.

Maldistribution continues to be a matter of concern to us. Incentives to schools to establish outreach programs in underserved areas have been a part of the Nurse Training Act, and studies show that a large proportion of nurse practitioners do provide health services to the poor and minority groups.

Efforts to provide more nursing care in underserved areas are hampered by a lack of employment sites resulting from present reimbursement policies which do not allow reimbursement for nursing services.

I do feel the need to stress the urgency of retaining nursing student loans and scholarships. The availability of those funds really has made it possible for low-income students to become nurses. There is a real need to greatly increase the number of minority members in professional nursing and to help RN's achieve B.S. preparation.

In our full statement, we comment at length on various sections of S. 2375 and S. 2144. We hope that our information and recommendations will be helpful to this committee.

We thank you for the opportunity to appear here today, and I would be happy to answer any questions along with my colleagues.

Senator METZENBAUM. Thank you very much, Dr. Blakeney. If you have a reproduction of the chart that you showed, we can include it in the record.

[The prepared statement of Dr. Blakeney follows:]

AMERICAN NURSES' ASSOCIATION

TESTIMONY

ON

NURSE TRAINING ACT BILLS

To

Health and Scientific Research Subcommittee
Labor and Human Resources Committee
U.S. Senate

March 12, 1980

By

Hazle Blakeney, R.N., Ed.D.
Chairperson, Department of Career Programs
University of Maryland School of Nursing

Summary of Points in ANA Testimony on the NTA

1. The American Nurses' Association supports S. 2375 and several sections of S. 2144.

2. Hospitals and other employers of nurses are experiencing a severe shortage. While the supply has risen dramatically in recent years, so has the demand. The situation is aggravated by high turnover caused by the intensity of care required by shorter patient stays and today's technology, frustrations of nurses about staffing, low salaries and lack of autonomy in practicing their profession.

3. Efforts to provide more nursing care in underserved areas are hampered by lack of employment sites resulting from the present reimbursement policies which do not allow for reimbursement of nursing services. The lack of a realistic definition of nursing shortage areas has been a serious problem as well. S. 2375 addresses this issue and provides for appropriate corrective steps to deal with it.

4. The priority of need for advanced preparation of nurses is recognized in the Senate bills. The need for nurses prepared as clinicians, nurse practitioners, supervisors and administrators of nursing services, teachers in schools of nursing, researchers and for other nurse leadership positions.

   We feel the clinical specialist preparation projects could be combined with the advanced training grants section, thus allowing the "clinical training" projects to be demonstrations for new approaches to teaching clinical skills and funding studies to promote more effective utilization of nursing skills.

5. Institutional support - Both S. 2375 and S. 2144 provide for institutional support based on meeting certain national priorities. However, we prefer the non- project grant approach in S. 2375 as it ties in to the size of enrollment as well as providing bonuses for schools that are doing specified things that do need to be fostered (minority recruitment, enrollment of RN's, practice in underserved areas).

6. We support the emphasis through institutional bonuses for programs to recruit and retain minorities in nursing. Successful projects completed in recent years should be publicized, duplicated and fostered.

7. S. 2375 includes a large-scale nursing student loan program administered by the Bureau of Health Manpower, Health Resources Administration. We agree that student aid of a separate nature is needed for nursing and other health professions. Service payback provisions could prove difficult to administer in light of current shortage area definitions. However, S. 2375 addresses that issue and we support that loan provision with the earmarking of funds for nursing. We are advised that RNs enrolled in B.S. programs will be eligible for these loans as they have special needs.

8. The continuation of traineeships to enable more nurses to get advanced preparation is fully supported. We urge that evaluation of the stipend level be done to determine its appropriateness in these inflationary times.

9. The legislation includes grants and contracts for projects for the improvement of nursing education. S. 2375 and S. 2144 both provide authorizations for this purpose. The authorizations are low and we

urge that any earmarking of funds be clearly identified to be relative to new awards. Otherwise, on-going grants would be terminated.

10. We support the clinical training grants section of S. 2375, and hope it will provide for demonstration projects in a variety of clinical settings on innovative nursing programs, faculty joint appointments projects and new cost-effective methods of providing nursing service. The direct feedback to the nursing school curricula from such clinical demonstration centers will greatly improve the realistic preparation of nursing students for today's and tomorrow's needs.

11. We urge that the collection of nursing data not be duplicated by government units. Currently the NLN, ANA, Department of Labor and others do collect, analyze and distribute certain nursing data as described in Section 808 of S. 2144. Any requirements for the government to collect data, etc. should not replace or duplicate those efforts but should focus on possible gaps and coordinate reporting.

12. The ANA supports the continuation of the National Advisory Council on Nurse Training, retaining its current functions of recommending grants for approval and advising the Secretary on policy matters pertaining to nursing education.

Mr. Chairman, we would like to thank this committee for their concern for nursing education and for the very carefully constructed and thoughtful bills which have been introduced to provide federal support to nursing schools and students. We support S. 2375 and several sections of S. 2144.

As you will recall, last year the Administration did not present its Second Report to Congress on the Nurse Training Act until the very night before the hearing scheduled by this committee. And there was need for committee action at that time only because the President had pocket-vetoed the bill passed overwhelmingly by Congress in 1978. We greatly appreciated your swift response and support. We also commend your knowledge and understanding of the importance to health care in this country of continued federal support to nursing education. We only wish the Administration were so perceptive.

We understand the need for budget restraints and the need to evaluate program cost effectiveness, but I would submit that this is the only program (or certainly one of a very few) that undergoes sunset review every year. We are discouraged by the Administration's inability or unwillingness to acknowledge the changing nursing role in health care and the increasing demand for nurses and recommend the kind of assistance that is needed to strengthen nursing's effort to provide adequate nursing service now and in the future.

The Secretary of the Department of Health, Education and Welfare states flatly that there is an adequate supply of nurses and that the only problem is "to keep a higher proportion...actively in the profession."

This is an oversimplified assessment. While there are a number of factors that impact on nurses in the work place, there is also a greatly increased demand for nurses.

You have only to read the help wanted ads in papers throughout the country or ask the directors of nursing services or the American Hospital Association to know that there are severe nursing shortages. A 1979 AHA survey of state hospital associations showed that 9 out of 10 states or a total of 39 states and the District of Columbia reported shortages ranging from spotty to critical. A National League for Nursing survey of Community Health agencies shows 34.8 percent vacancy rate in budgeted RN positions.

We would agree that the shortages are not only a matter of numbers. The problem is more complex.

It is not, however, a problem of retaining nurses in the profession. According to our nationwide sample survey, there are some 1.4 million RNs who hold current licenses to practice. Of those, over 70 percent are employed in nursing. This is considered a very high proportion. It is much higher than the labor force participation rate for all work-eligible women which is about 56 percent. For those who are college graduates, the figure is 61 percent.

Of the less than 30 percent of nurses who are not employed in nursing, the survey found only about 62,000 to be working in another field; more than 42,000 had children under six years of age; 42,000 were seeking employment and about 104,000 were over 60 years of age.

As the Administration itself points out in its Second Report to the Congress, "even with [the high growth rate in supply], registered nurses are being absorbed into the work force at a high rate."

About 601,000 nurses work in hospitals, an increase of nearly 16 percent since 1972. The increased demand reflects changing patterns in care. More nurses are needed for intensive care, coronary care, and emergency care units. A trend toward shorter hospital stays means that patients in the hospitals are sicker requiring a high degree of complex nursing care.

Nearly 80,000 RNs work in nursing homes and extended care facilities, a 42 percent increase over 1972 when the last previous survey of nurses was conducted.

And the need for nurses prepared for care of the elderly is continuing to expand as a greater proportion of our population reaches the older years.

The greatest increase in employment of nurses since 1972 involved care of non-institutionalized persons. The number of nurses in public health agencies and other community health settings is more than 77,000, up from about 41,000 in 1972.

A recent announcement from the Robert Wood Johnson Foundation illustrates the increasing use of nurses in new or expanding roles. The Foundation will make grants to eight hospitals to establish projects to offer better, long-term care for ambulatory patients with chronic illnesses. Specially prepared nurses will staff the ambulatory care facilities and manage the patients' care.

The Administration's Second Report to Congress on the Nurse Training Act accurately notes that shifts in the delivery of health care from institutional to ambulatory and home care settings "would require nurses skilled in assessing health states, in applying techniques to maintain health and prevent illness, and in assisting individuals and families to cope with the effects of illness and disability." The report also comments that "pressures to control escalating costs of hospital care might encourage greater use of nursing homes, rehabilitation centers, and convalescent care facilities, where nurses are the primary providers."

The report states that in acute care settings, "the complexities of care and the use of sophisticated treatment modalities...would further point to the consideration of the need for nurses with advanced preparation in special areas of practice." The report fails, however, to make the conclusion that nurses with such specialty preparation must be drawn from the current supply, thus increasingly depleting the regular ranks of nursing.

It also is interesting to note in this connection that the Administration budget does not even include funds for advanced training.

One cause of the shortages being experienced throughout the country is turnover. The very intensity of care required by today's technology, frustrations of highly qualified nurses about lack of autonomy, and low salaries all contribute to turnover.

This situation was well described in a recent article in U. S. News and World Report: "The beginning of independence for nurses came in the 1960s with the revolution in medical technology and the development of intensive care and coronary care units. No longer was it always the doctor who saved lives. Now it was often the nurse, wielding space-age machines of medicine, who assumed much of the power to heal."

Speaking of nursing's new responsibilities, the article notes that there also are new problems. "Burnout and low morale are major hazards...Turnover rates are particularly high in hospital intensive care, coronary care, burn and cancer units.

"The average tour of duty of nurses in intensive care units, for example, is 18 to 24 months. Nursing officials point out that in an ICU, the nurse is in constant contact with the patient. Often, there is no time even for a coffee break. Many patients, moreover, are terminally ill..."

"Nurses have to be in gear every single minute. This is wearing on them emotionally and psychologically."[1]

Considerable sympathy for nurses' problems and frustrations was expressed during recent strikes in New York City. At one hospital, the settlement provided for the hiring of 200 additional nurses and the end of non-nursing duties such as answering phones. One hospital executive vice-president was quoted as saying, "we fully understand the sentiments of the nurses and share the frustrations that forced them to these desperate measures..."

The average annual salary for an RN employed full-time in a nursing position is about $13,000. For staff nurses they range even lower, and there is a relatively narrow salary range for increases - about $13,000 - $17,000 - that nurses can anticipate for years of experience.

Maldistribution also continues to be a factor and a matter of concern to the nursing profession. As you know, incentives to schools to establish outreach programs in underserved areas have been a part of the Nurse Training Act. A recent study showed two-thirds of nurse practitioner respondents stated that the majority of their patients were poor, while one-third served predominantly minority populations. While the majority of nurse practitioners and nurse clinical specialists included in the study do not work in inner-city or rural areas, a large proportion of nurse practitioners do provide health services to the poor.[2]

There has been increasing evidence of a willingness of nurses to serve in underserved areas, but there are many obstacles to such service. Experience under the Rural Health Clinic Reimbursement Law (P.L. 95-210), for example, has shown numerous problems with administration of the law and in a number of states strong opposition from medical societies to nurses functioning in this manner. Problems have been encountered also under Section 822(b) of the Nurse Training Act (as amended by P.L. 95-831) which provides traineeships for nurses from rural areas who agree to return to rural areas to practice. Efforts to provide more nursing care in underserved areas are hampered by lack of employment sites resulting from present reimbursement policies which do not allow reimbursement for nursing services.

There is also a need for new criteria to be developed by Health, Education and Welfare in designating nursing shortage areas. What is currently being used are medical, not nursing, criteria. S. 2375 addresses this issue well.

New NTA Proposals

We are pleased that the bill introduced by Senator Kennedy and several members of his Committee and Senator Schweiker's bill would extend nursing education assistance for a longer time than recent bills have, the Kennedy bill through 1983 and the Schweiker bill through 1984. In recent years, the short periods of extension, Presidential vetoes, and low Administration budget requests have been a source of uncertainty and confusion both to schools and students. A longer period is needed to give programs a fair chance to work most effectively.

In addition, the longer time span would be appropriate in terms of anticipated completion of the Institute of Medicine study authorized under P.L. 96-76, the

Nurse Training Amendments of 1979. That allows for a preliminary report to the committee and a final report two years later. We understand there has been a delay in getting the study underway and it seems doubtful that the original deadline will be met. The delay was caused partially by the Administration's attempt to reprogram $750,000 from capitation money to finance the study rather than using other funds appropriate for this purpose.

General Comments

We would like to make a few general observations on S. 2144 and S. 2375 and then comment on several specific sections of the bills.

We support the provisions for the safeguarding of personal privacy in both bills. This is an important consideration in any government program and students should be informed of their rights as to the need for providing the information and use to be made of it.

Both Senate bills make provisions for rather extensive biennial reports on nursing statistics. We recognize the need for all of the items identified. However, we feel the committee should clarify its intent so that already well-established data sources (Department of Labor, NLN, AHA, ANA, etc.) are not ignored and duplicate efforts made. We feel that contracts for collection and analysis of such data is appropriate, and where valid statistics are not now available, the agencies identified would be justified in collecting their own figures. Coordination is required to avoid different methodologies that result in conflicting interpretations and unnecessary costs.

We note that the nursing portion of S. 2375, Title II, is called the Nurse Education Amendments. We endorse use of the word "education" in preference to the outmoded term "training" which has been the term used historically. Education accurately denotes the modern day preparation of the professional registered nurse, and we welcome the change.

Institutional Support - National Priority Incentive Grants

Section 810 of S. 2375 is a very carefully constructed program for institutional grants that will target limited funds on the major priority needs in nursing. We support and applaud this section, the bonus emphasis on minority recruitment enrollment of RN's in baccalaureate programs and the practicing in underserved areas of graduates from the school. We know that schools of nursing will be constructively responsive to the issues highlighted by this section and we urge its prompt enactment. The authorizing levels are low for the number of schools and students involved, and we ask that this be looked at for increases if at all possible.

Advanced Training

We agree with the emphasis which both S. 2144 and S. 2375 place on advanced training and nurse practitioner programs. As we have noted, the increasing demand for registered nurses is particularly acute for those with advanced preparation. In its publication, Graduate Education in Nursing, ANA's Commission on Nursing Education gives high priority to the "preparation of highly competent leaders to function in diverse roles as nurse clinicians, researchers, theoreticians, teachers, administrators, consultants, public policymakers, systems managers and as colleagues on multidisciplinary teams."

Despite advances that have been made in recent years, less than 18 percent of nurses have baccalaureate degrees and only 4.1 percent are prepared at the master's or doctoral level. Master's degrees were awarded to 4,271 nurses in 1977-1978.

Just as medical and health care are increasingly complex, nursing is an increasingly complex field requiring extensive knowledge of both the physical and social sciences. Advances in biomedical research require well-qualified nurses to care for patients benefitting from new surgical and other new techniques of treatment. The Western Interstate Commission for Higher Education, which last year completed its HEW commissioned study on current and future needs for nurses, said that by 1982, 64 to 66 percent of registered nurses should have baccalaureate or higher degrees. While we will not reach that goal, the need to continue to place high emphasis on this area is obvious. We urge that all nurse practitioner programs be at the graduate level in nursing schools.

Funds to greatly expand and improve such programs are badly needed. Unqualified faculty and nursing administrators are working under great pressures, and educational opportunities for those already in the field and for more recent graduates of basic programs is essential.

We have some concerns about separating out the clinical specialist projects from the faculty and administrator projects as it is so essential that the two groups be brought together in the educational program. This may be a point of unnecessary concern, but we would like to explore this aspect more fully with you.

Special Project Grants

This provision of the Nurse Training Act has brought about several types of improvement in the teaching of nursing. It also has assisted schools in recruiting minority students, meeting local needs, participating in regional programs and in improving faculty abilities to respond to changing student groups.

We urge continuation of this program. Any earmarking of funds or prioritizing for funding purposes should be related to new awards only as ongoing projects would be cut off before completion if the set aside of funds were to include continuation awards.

This provision cannot be seen as a substitute for the current capitation grants provision.

Financial Distress Grants

It is the ANA's feeling that solid institutional support of a stable nature will prevent most schools from getting into serious financial difficulties. However, we recognize that there are some schools in special circumstances, that if provided adequate short-term financial assistance would be able to survive and to conduct high-quality programs.

Examples that come to mind are the historically black private institutions that have provided nurses for large numbers of American institutions for many years.

With limited endowments and ever-increasing competition for faculty, and faced with recent inflationary pressures, they do have special needs for financial assistance.

We support the inclusion of those sections (Section 811 and Section 812) in the final version of this bill.

Start Up Grants

The expansion of nursing schools that occurred in the late 1960's has brought the total of programs to 1350. In light of faculty shortages and the need for regional planning to meet needs we suggest that rather than Section 813 in S. 2144 being a separate program, assistance to new schools could best be provided for as one of the options under the special project grants section. In that way priorities for new schools will be combined with other priority considerations avoiding the potential opening of unnecessary programs at this time. The authorization provided for this section we suggest should be added to the Special Projects section.

Minority Recruitment

We are pleased that both S. 2144 and S. 2375 have provisions that would assist schools to recruit minorities and individuals from disadvantaged backgrounds into the profession. An amendment to encourage minority recruitment was first introduced by Senator Javits some years ago.

Many good results have been achieved. An Albany (Ga.) Junior College Department of Nursing remediation project, for example, has resulted in 160 graduations from the nursing program, 157 who passed state board examinations and 98 percent holding full-time jobs in nursing. Local hospitals and nursing homes in a radius of 50 miles are staffed primarily by Albany Junior College graduates. Minority admissions have risen to about 10 percent, an increase of 75 percent, in a project at the Ohio State University School of Nursing which includes recruitment, counseling, and affirmative socialization among minority and majority students and nursing faculty. The retention rate of minority students is 99 percent.

However, we feel that there is need for a new look at this program and for new impetus. In 1965, blacks comprised only 2.9 percent of all nursing student enrollment; at the time, the total RN work force was approximately 3 percent black. Ten years later, the representation of black students had risen to 12.3 precent of the total admissions, 8.3 percent of the total enrollments, and 9.2 percent of the total graduations from nursing school programs. However, the RN nurse corps remains predominately white (95 percent).[3]

Construction Grants

Several schools face serious space limitations while others need facilities for outreach teaching centers. We think the need for such renovation and expansion projects should be more fully documented prior to the expiration of this legislation but that in the meantime, limited construction grants do need to be available.

Student Assistance

We support the subsidized interest loan provisions, with the contingent loan forgiveness for service in underserved areas in S. 2375. The time limitations on liability for assignment to underserved areas are such that students should be able to plan their careers to include such service should it be found to be necessary.

In these very inflationary times, interest subsidies are a most meaningful way to aid students. The 5% interest charged to the nursing student will make this program possible for many needy students.

The deferral of loan repayment provision in S. 2375 and S. 2144 seem appropriate for both undergraduate and graduate nursing students.

The 30% set aside from the amounts issued to the Secretary will, we hope, be a minimum and in no way seen as the upper limit of funding, for there are by far more nursing students than all other health professional students combined and their costs are equal to those of the other groups at undergraduate and graduate levels.

RNs enrolled in B.S. programs should be eligible for loans.

Title VII

Scholarships

We urge the continuation of the nursing scholarship program for the exceptionally needy as in S. 2375. Appropriate utilization of this provision in combination (based on the individual students' circumstances) with the subsidized loans should make nursing a career possibility for any qualified student.

Traineeships

The need for continuation of this program has been questioned by the Administration yet they never document their side with facts. Nursing fully supports and, in fact, feels these grants are essential for the person who has the real potential for leadership yet, due to family circumstances, does not have the ability to fully finance his/her own graduate education. This includes single parents, older nurses with financial demands from families, yet who have a lot to offer the field, and others. With the availability of loans, once more, we think the traineeships should be targeted carefully as those in real need for such support.

Comments on National Health Service Corps Scholarship Program

The effectiveness of public health/community nurses and primary health care and other categories of nurse specialists and practitioners in rural and other underserved areas is well established. To function effectively in those professionally isolated settings requires both broad and deep clinical preparation and extensive nursing experience.

It is our belief that the NHSC Scholarship Program has not aggressively promoted the inclusion of nurses in its ranks. By this we mean that students have not heard about the possibilities of those scholarships early enough in their programs to make the career decisions required. A fair proportion of these scholarships should be available to nurses.

Demonstration Projects

In a report to the President and Congress ten years ago,[4] the Division of Nursing, HEW, noted that: "Maximum utilization of nursing skills requires improved employment conditions, especially hours of work and salary; increased use of part-time schedules for nurses who have homemaking and other responsibilities; innovations in on-duty schedules, improved administration of nursing services to relieve nurses of non-nursing duties; and improved ways of redistributing the nurse force to keep abreast of the movement of health services to out-of-hospital nursing care and to overcome the imbalance in geographic distribution of nurses."

What is needed are demonstration projects in a variety of settings--large teaching hospitals, smaller hospitals, home health settings--using faculty and students on new, cost-effective methods of providing nursing care.

A number of examples are available such as the University of Rochester (N.Y.) School of Nursing unification model where students and faculty provide primary care in and function as a part of nursing service in the hospital and the College of Nursing, Rush-Presbyterian-St. Luke's Medical Center in Chicago, where the practitioner teacher model is coupled with RN responsibility for total nursing care.

Such demonstration projects provide new approaches to both nursing education and service and give students first-hand experience in providing high quality nursing care.

Loretta Ford, co-director of the first nurse practitioner demonstration project and currently dean of the School of Nursing, University of Rochester, makes the point well: "The intent of the first nurse practitioner demonstration project was to determine the safety, efficacy, and quality of a new mode of nursing practice designed to improve health care to children and families and to develop a new nursing role - that of the pediatric nurse practitioner....I was confident that nurses could be prepared to meet those [unmet health needs of people of all ages in the community] by facilitating access and promoting continuity and coordination of care."[5]

It is acknowledged today that pediatric nurse practitioners can provide up to 80 or even 90 percent of care required. It is such demonstration projects and results that are needed.

We recommend that there be a separate demonstration grant authority to the legislation and that it be funded at a level that will allow effective use of the technique to improve and expand the potential of nursing services in all health care delivery settings.

Comments of S. 2378 - Health Care Management Improvement

We support the inclusion of nursing in this bill but we do hope it will not cause confusion relative to the advanced nurse training section of the nursing amendments. The preparation of most nursing administrators does occur in nursing school graduate programs.

The ever increasing emphasis on health care cost controls, cost effectiveners, increased productivity and limitations of resources has greatly increased the importance of well-qualified administrators in every setting where nursing care is provided.

Area Health Education Centers

We support the continuation of the AHEC program. In fact we feel it has been one of the major factors in attracting and retaining health professionals in rural areas. Nurse practitioners and public health nurses certainly can and do benefit from the support and clinical updating offered by the AHECs.

Mr. Chairman, we thank you for the opportunity to appear here today and we would be happy to answer any questions.

NOTES

1. "For 'New Nurse'; Bigger Role in Health Care," U. S. News and World Report, January 14, 1980, pp. 59-61.

2. Eleanor G. Feldbaum, R.N., Ph.D. "Will Nurses Alleviate Health Service Maldistribution Problems?" Nursing Administration Quarterly, Vol. 4, No. 1, Fall 1979, pp. 61-66.

3. John Buckley, "Faculty Commitment to Retention and Recruitment of Black Students," Nursing Outlook, January 1980, p. 96, ANA's Sample Survey shows 6.2% of the RN population from racial or ethnic minority backgrounds. For those actively employed in nursing, the percentage is 7.5%.

4. Progress in Nurse Training-1980, a report to the President and Congress, Department of Health, Education, and Welfare, Public Health Service, Division of Nursing, June 30, 1970, p.86.

5. A Nurse For All Settings: The Nurse Practitioner," Nursing Outlook, August, 1979, pp. 516-521.

Senator **Metzenbaum**. Dr. Carolyne Davis, representing the National League for Nursing.

Dr. **Davis**. Thank you very much.

It is my privilege to appear before the distinguished subcommittee today representing the National League of Nursing. I am currently the associate vice president for academic affairs at the University of Michigan, and formerly dean of our school of nursing at the University of Michigan.

Part of my current activities involves coordination of activities among our five health science schools of dentistry, medicine, nursing, public health, and pharmacy.

I think that the root of many of our problems is overestimation of supply of new registered nurses, as well as underestimation of the demand of the use of the registered nurses. We do have another chart here, Senator, at this point.

This chart refers to the overestimation of supply. It was indeed anticipated that there would be a drop in enrollments in the field of nursing education, but it was not anticipated that those drops would occur soon or as abruptly as it actually occurred.

If one looks at the 1976 data, that was last year where there was actual data before the projections; that is, in the purple area there, this actuality, you will notice, in 1977 we were 4,000 under the projected graduation from schools of nursing. By 1978, that figure had dropped, so that it was a 6,000 differential; and in 1981, we predict there will be a difference between what was projected and what actually will occur of approximately 10,000 students. This, I would remind you, occurs even with the modest institutional support that we now have.

I would also like to remind the panel that we have had a significant decline in graduations of approximately 2 percent, which has only started as of this year.

In regard to the underestimation of the demand, the second report for Congress also predicted there would be a 22-percent increase in nurse utilization because of the impact of strong cost-containment programs; while an expert panel also looking at the same material believed that there would be a 48- to 100-percent increase in nurses. I think it is significant that indeed changes have occurred in the health delivery system since 1972 to dramatically demonstrate increased utilization.

Not only do we have more nurses being utilized in nursing homes and home-care agencies; we have seen a significant increase in staffing levels in acute-care hospitals.

Let me illustrate my point by my own hospital's example.

At the University of Michigan, in the last 5 years, we doubled the budgeted number of positions in a variety of our intensive-care units, such as the burn unit, pediatrics intensive care and newborn nursery areas.

At the same time, we have also significantly increased the staffing for nursing in our general medical and surgical areas. The University of Michigan Hospital is quite like the other hospitals in the Nation; we, too, have suffered from the inability to hire staff as we would like.

Currently, we have 22 percent of our nursing positions vacant. We have closed beds; we have closed operating rooms; and gone to the use of overtime of our already overworked staff.

We have used temporary nurses and agency nurses and, where we could, we have used increases in nursing assistants and licensed practical nurses.

We need more nurses prepared at the masters level because we only have 4 percent of those prepared at that level now.

In closing, I would like to say additionally that nurses can contribute to the cost-effectiveness because we do have studies that show change in the delivery system can reduce hospital stay through judicious nursing.

In summary, the National League for Nursing is encouraged by the tremendous interest and support and cooperation of the staff and the committee. We are grateful to see preserved the concept of institutional support, because we believe that is still very badly needed.

We are also pleased to see scholarship programs that are recognized that are addressed in Senator Kennedy's bill and the most critical need was addressed in Senator Schweiker's bill for the funding levels, as proposed for advanced nurse training and traineeships.

We are pleased to submit our statement.

Thank you.

[The prepared statement of Dr. Davis along with additional material supplied follows:]

TESTIMONY OF

CAROLYNE K. DAVIS, R.N., Ph.D.
ASSOCIATE VICE PRESIDENT FOR ACADEMIC AFFAIRS
UNIVERSITY OF MICHIGAN

ON BEHALF OF

THE NATIONAL LEAGUE FOR NURSING

BEFORE THE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

H.R. 6802

TITLE III - NURSE TRAINING

MARCH 21, 1980

I am Carolyne K. Davis, Associate Vice President for Academic Affairs at the University of Michigan, and formerly Dean of our School of Nursing at the University of Michigan. In my current role, I am responsible for coordination of activities between our five Health Science Schools of Dentistry, Medicine, Nursing, Public Health, and Pharmacy. In addition to these units, I work with our University Hospital, a large teaching facility.

I am testifying today on behalf of the National League for Nursing, the largest American coalition of nurses and other health professionals, consumers and home care agencies dedicated to developing and improving the standards of quality nursing education, nursing services and health care delivery in the United States.

I appreciate the opportunity to appear before this distinguished Subcommittee to present our recommendations regarding the Nurse Training Act.

The basic tenent of our statement today is this: We deem it imperative that the Federal Government provide additional fiscal support to both institutions and students engaged in nursing education at appropriation levels equivalent to those in existence in 1978 (as provided for in P.L. 94-63). The alternative is to further exacerbate an already critical shortage of nurses.

The detrimental impact of the excessive reduction of federal support to nursing education initiated by the Administrative budget requests and proposed authorization levels for FY 1979 and FY 1980, is already having a deleterious effect throughout our health care delivery system.

The nation is entering what may be the biggest nursing shortage ever. Only a few of the nation's 6,732 hospitals and 13,417 nursing homes have a full complement of registered nurses. Critical nursing shortages are being reported from all regions of our country. Some institutions, unable to find enough nurses to fill required positions, have had to close beds, or even entire units, such as, operating rooms and special intensive care areas. The shortage of nurses in many states has hit crisis proportions among hospitals, nursing homes and home health agencies. The American Hospital Association has stated that an additional 100,000 nurses are required now in order to fill current institutional needs. Empirical evidence of shortages is available from all areas of the country. Newspaper articles, advertisements and state surveys all provide evidence of the mounting crisis in nursing supply. Data available from a sample of states reporting shortages are summarized below.

California -- In its most recent survey, the California Hospital Association reported that unfilled budgeted vacancies constituted 17 percent of the State's full-time nursing staff, and that the projected number of openings state-wide exceeds 8,300. Nearly 90 percent of the hospitals responding to this survey indicated that an additional 1,051 RNs would be needed by 1982. Documented shortages of nurses have now surfaced in all states except Rhode Island and Delaware.

New Jersey reports over 600 RN vacancies.

Georgia -- In a November 1979 survey by the Georgia Hospital Association, approximately one out of every eight full-time budgeted RN positions is not filled. (1,800 budgeted vacancies.) Shortages of nurses are reported throughout the state, not only in the larger communities, but the smaller ones as well.

Texas -- Based upon a January, 1979 survey, estimates indicate that there are 4,129 budgeted unfilled positions for RNs in Texas hospitals. These unfilled positions represent over 12 percent of available positions for RNs. Specific statistics include:

. Positions currently budgeted and unfilled	4,129
. Additional positions for expansion of existing facilities and/or new or expanded services during the next twelve months	2,707
. Additional positions for job reclassification during the next twelve months	854
. Additional positions to replace those who will die, or otherwise leave the hospital industry during the next twelve months	1,327
. Total positions anticipated now and over the next twelve months	9,017

Maryland -- In Maryland, the shortage is escalating. Specific examples include:

- At the University of Maryland, out of 750 budgeted RN positions, 75 are unfilled.

- At Sinai Hospital (Baltimore), 43 positions out of 340 FTE are unfilled.

- At City Hospital (Baltimore), 80 of 300 budgeted positions are unfilled.

- Prince Georges County (Baltimore), 83 of 400 positions are unfilled.

Ohio -- The Ohio Bureau of Employment Services reported that shortages of registered nurses were reported in 50 of Ohio's 88 counties.

In general, smaller community hospitals have fewer staffing problems and lower turnover than hospitals in larger cities. A notable exception is the large rural southeastern Ohio area which has a very high percentage of vacancy and turnover rates.

Pennsylvania -- The Pennsylvania State Hospital Association reported 1,550 budgeted vacancies.

Tennessee -- A THA 1979 survey indicated that there are 9,721 RNs employed in hospitals, representing 60 percent of the total nurses employed. Hospitals responding to the survey stated that if they were able to, and if the numbers would be available, they would like to employ an additional 1,997 RNs. If these figures are projected five years hence, the hospitals would need to employ an additional 5,232 RNs.

The heaviest shortage areas are in West Tennessee and Mideast Tennessee. The Memphis area has the next highest shortage of RNs. The Western Tennessee area's need in five years is projected to increase by 152 percent, South Middle Tennessee 154 percent, and Mideast Tennessee 107 percent, and Memphis, 49 percent.

With regard to hospital beds that have closed due to the shortage, the City of Memphis Hospital has closed 37 beds, and Rutherford Hospital in Murfreesboro has closed a wing. Vanderbilt University is functioning on a staff consisting of 2/3 temporary placement nurses. With regard to registries, temporary pools have grown. In Nashville, for example, four such pools exist with three more scheduled to begin operation shortly.

Indiana -- The Indiana Hospital Association revealed that 84 Indiana hospitals had 1,110 budgeted vacancies for full-time equivalent registered nurses. The number of RN vacancies was 55 more than reported last January, indicating a continued increase in the demand for nurses.

Mississippi reports over 1,000 RN vacancies.

Iowa -- In an April, 1979, survey by the Iowa Hospital Association, data indicated that the greatest number of unfilled positions for RNs occurs in institutions over a 200 bed size, but less than 400 beds. The least number of unfilled positions for RNs is in hospitals that have 101 - 200 beds.

Utah reports a state-wide shortage with approximately 1,000 vacancies.

Virginia -- In a 1978 survey by the Virginia Hospital Association, 15 percent of the hospitals responding indicated that beds have been closed due to a lack of staff with a range of beds closed from two to 52. Fifty-nine percent of the hospitals responding indicated that an additional 1,051 RNs would be needed by 1982, amounting to an 11 percent increase.

Louisiana reports 1,200 budgeted vacancies.

New York -- In the New York City area alone, 1,100 staff nurse vacancies are reported. One dramatic example is Bellevue Hospital where it is reported that many times one nurse has the sole responsibility for 40 patients on any evening shift.

Illinois -- In the Chicago area, 86 hospitals have reported a shortage of 1,083 RNs.

In the face of this crisis, we find it unconscionable that the present Administration is unyielding in its determination to decimate Federal financing for nursing education programs. The Administration, in its budget request for FY 1981, has proposed slashing nurse training funds from the present 1980 level of $106 million to $28.6 million. (This is even more disconcerting when considered in the light of the FY 1978 authorization levels of $206 million.) Embodied in the Administration's FY 1981 request is the total elimination of support for capitation grants, financial distress grants, construction assistance, advance nurse training grants, traineeships, scholarships, student loans, and support for nursing research.

A May 1978 CBO report to Congress entitled, "Nursing Education and Training: Alternative Federal Approaches," stated the following:

> "In fiscal year 1979, $20.9 million would be targeted to nurse practitioner programs and special projects. All other programs would be terminated. As a result, substantial decreases in the aggregate supply of RNs and a large drop in the supply of RNs with graduate training might be expected." (Underlining added)..."In addition, nursing students would be forced to assume a greater share of their educational costs by paying higher tuition charges." (p.xv.)

In recent years, Congress has demonstrated its sensitivity to the needs of nurse training programs by restoring much of the funding support which the Administration has attempted to eliminate. Apparently, as demonstrated by its FY 1981 budget request, the Administration has paid little attention to the stated concerns of Congress. This Subcommittee, however, has been consistently supportive of Federal funding in the broad areas of nurse training.

The profession of nursing is one of the oldest in this country and indeed, the world itself. While many facets of nursing have changed over the course of time, one factor remains constant: it is the nurse who serves as the primary and cohesive link which binds all of the health professions and delivery mechanisms in obtaining the ultimate goal -- the provision of quality care to the patient. This basic function is one of the pillars of strength of our health care system. It is the nurse who provides the 24-hour contact with the institutional patient - monitoring, assessing, treating, and coordination of care. It is the nurse who functions as the basic component in the delivery of health services outside of our hospitals and nursing homes, through home health agencies, community outreach programs, school nursing, public health nursing, and numerous other voluntary organizations. It is the nurse who, within all of these levels of care is responsible for the communication and coordination between health professionals and the patient.

As the nation pays more attention to preventive medicine and diseases of the aged, there is a consensus among health planners that nurses can play an expanding role in the delivery of these services. The role of the nurse as a "patient educator" offers hope for our Nation's health status through the day-to-day repatterning of behaviors toward healthier values and activities. The nurse is the only health care provider prepared with a knowledge base broad enough to encompass the entire range of activities and behaviors related to the health of the individual.

Perhaps this role is of greatest consequence with regard to the elderly of this country. The number of persons age 65 and over increase by over 500,000 each year. Our senior citizens rely primarily on nursing services since extensive nursing care - both institutional and home based - is often the main thrust of their treatment regimens. Already our long-term care facilities report a dire need for registered nurses. The Department of Labor reports a shortage of about 150,000 nurses in nursing homes alone. Current staffing levels indicate that these elderly patients only receive an average of 12.5 minutes of nursing care per patient per twenty-four hours. Therapeutic and rehabilitative care demands more adequate staffing with nurses skilled in gerontological practice. The hardships that will afflict the graying segment of this Nation because of a misguided Federal policy reducing both the numbers of available nurses, and the quality of care that they are able to provide, cannot be ignored. The elimination of existing Federal support to nursing education would have a devastating effect on the elderly.

The increasing Federal role in the provision of primary care services, through the establishment of different diagnosis and treatment incentives; the expanding emphasis on health promotion and prevention as well as the continued expansion of HMOs, through their reliance on nursing services, suggests a further rise in the scope and importance of nursing. Moreover, the consideration of alternatives to costly institutional-based services points towards the expanded use of home health care, a concept initiated and fostered by the nursing profession a century ago.

In this era of economic uncertainty and fiscal constraint, it is often overlooked that the nurse is the most cost-effective provider of care within our health care system. Through advantageous rate differentials, and cost-saving levels of health intervention, nursing is one of the basic cost containment tools available to our country.

Research data is now available indicating that changes in nursing care can affect recovery rates, recidivism and the success of preventive health measures. By varying the organization of care, nursing studies have demonstrated a 40 - 55 percent reduction in the average length of stay of patients with abdominal surgery and renal transplants. Nurse-delivered home and ambulatory clinic care, has demonstrated success in decreasing hospital utilization. As one example, nurse clinic patients return to employment at rates that are significantly higher than physician clinic patients even when corrected for types for disease, socioeconomic background, etc.

Nurse midwives have demonstrated their ability to deliver safe high quality personalized maternity care which is also markedly less expensive than traditional hospital care. Charges for nurse midwifery services at a New York City Child Bearing Center are 37.6 percent of in-hospital care. An audit report noted that the cost to Blue Cross for families delineated at the Center is 66 percent of the cost of the plan had the same family gone to a hospital setting.

Furthermore, it should be noted that decreasing the current ratio of professional nurses to patients in direct care settings has been shown to be a costly proposition. Less educated personnel, such as nursing aides may appear to be less costly, but require so much more supervision that this practice is actually more costly, in addition to the risk that is posed to the patient's well-being. Studies show that aides average about 25% "unoccupied time" during the work day and that nurses spend 35 percent of their time supervising aides and teaching them what to do for patients.

It is difficult to imagine how an Administration so concerned with the containment of health care costs can ignore the cost-effective nature of nursing and proceed on a course which endangers the stability of the nursing profession.

The supply of and demand for nurses has been a subject of much controversy over recent years. The Administration has relied on reports that suggest that by 1985, the supply and demand for nursing personnel will be in balance. Inherent in this report were several assumptions. First, there would be no major changes in the health care delivery system and that staffing levels per inpatient would increase by only 22 percent. Second, "due to data availability, the year 1972 was critical. In the case of the requirements model, increases noted for the projection period are based upon that year." (p.77.)

This same study concluded that should there be a significant expansion of nurses' roles and responsibilities, the number of nurses required by 1985 could be as high as 1.6 million. However, the Report concluded that:

> "The overall RN requirement range projected for 1985 is between 1,205,600 and 1,716,400 based upon Vector Research. The most likely case based upon an assessment of the model assumptions compared with prevailing conditions in the health care system and current policies yield a requirement range of 1,205,600 to 1,316,300 and probably at the low end of the range. It is concluded that the aggregate national requirement and supply for 1985 will be in balance." (p. 94.) Second Report to Congress Nurse Training Act of 1975.

Other evaluations of the situation have reached substantially different conclusions. A panel of experts appointed to assist in supplying data necessary to complete these studies predicted that, within the context of expected societal changes, the demand for full-time RNs in 1982 would increase from 48 percent to 104 percent above 1976 figures. The panel included experts in the fields of nursing, health education, hospital and health administration, health research and economics.

DHEW retorted that the chances of this assumption becoming a reality, however, are very remote. Increased utilization of health services is inconsistent with the Administration's policies. "These estimates," the DHEW noted, "do not take into consideration the potential impact of strong cost containment efforts." There is indeed no simple answer to the complex problems of predicting future requirements. However, one thing is certain, significant changes in health care delivery have occurred since 1972, especially in terms of the nurse's role. In most tertiary care settings, the number of RNs per patient has increased significantly as the total patient care mix has moved closer toward intensive care due to the significant decline in the length of stay and increasing technological complexity.

Let me illustrate this phenomenon by two examples of nurse staffing with which I am familiar. At Johns Hopkins Hospital, the nurse staffing pattern for a 14 bed Pediatric Intensive Care Unit has changed dramatically in the last several years alone. In 1976-77, this unit was staffed with one head nurse, one clinical specialist, 18 registered nurses and 10 nursing technicians. Current projections for the 1980-81 year indicate budgeted staff required as one head nurse, one clinical nurse specialist, and 36 registered nurses, with the elimination of the ten nursing technicians. This is an RN staffing increase of 100 percent for that unit alone.

At the University of Michigan University Hospital, our registered nurse staffing requirements for the Newborn Nursery Intensive Care Unit has gone from 37 budgeted positions in 1974-75 to 62.4 for the 1979-80 budget year. Likewise, our Pediatric Intensive Care Unit staffing positions for nursing have risen from 17 in 1975-75 to 46.8 in 1979-80, while our Burn Unit now calls for 46.3 budgeted nursing positions in contrast to 1974-75 when we utilized only 28 nurses. Even in our non-critical care areas our nurse staffing has increased significantly as demonstrated by the following: a single surgical unit has increased from 25 positions in 1974-75 to 38.6 in 1979-80, and a medical unit has added 11.7 nursing positions to its budgeted nursing staff since 1974-75.

Not only has the average daily occupany rate increased in these units, but also, the intensity of care has increased significantly with more registered nurses needed to carry out such special care activities as monitoring vital functions, ventilation therapy, intravenous therapy with infusion pumps, and the handling of other special technological care.

Modern advances in treatment of patients with bone transplants, radical surgical interventions, burn therapy, neurosurgery and cardiac surgery require intensive care on a twenty-four hour basis. Many intensive care areas now require a 1:1 nurse-patient ratio in order to deliver safe and effective quality care.

While the actual number of nurses needed to meet today's requirements is the subject of great controversy, the fact remains that the supply of new graduates has now declined and the initial assumptions concerning the ability of the supply to adequately meet the 1985 needs are erroneous. Let us examine now some aspects of the debate:

Secretary Harris in her recent testimony before the House Appropriations Subcommittee on Labor-HEW, stated, "We are requesting a reduction of $78 million in the support of nursing education programs because the aggregate supply of trained nurses is adequate. The test now is to keep a higher proportion of trained nurses actively in the profession."

The Second Report to Congress, Nurse Training Act of 1975, overestimated the number of graduates anticipated from schools of nursing from 1976-77 until 1985. (Figure one in the Appendix shows these projections graphically along with the actual graduations according to NLN data.) More accurate projections based upon actual admissions have recently been prepared by the National League for Nursing. This year for the first time in a decade, graduations from basic nursing programs declined almost two percent. However, the prediction of supply in the Second Report to Congress, while anticipating a decline, did not foresee its occurring either this early or as abruptly, and therefore, we can already conclude that the predictions on the supply side of the equation are too high. Moreover, this early error in predictions will have a compounding effect in the next few years so that by 1985, the Administration's prediction and the actual supply will, in all probabilities, be widely divergent. In 1977, the projection was too high by a factor of 4,000; by 1979, the difference was 6,000; and the differences will continue to increase by 1981 to a difference that could approach 10,000.

These signs of decline in the output of nursing education go back to 1974 when the rate of increase in admissions dropped suddenly. Aggregate admissions have not grown significantly since 1974; and in 1978, the decline in growth rate of admissions was 3.6 percent. Applications to basic programs of nursing also declined 16 percent between 1977 and 1978, the first such decline since 1960. If this current downward trend in applications and admissions is allowed to continue, and the Administration succeeds in eliminating most Federal support for nursing education, the existing shortage will grow worse.

How many nurses are currently available for practice? A September 1977 survey by the ANA indicated 1.4 million nurses hold a license to practice. Of that total, 70 percent or 978,324 were in active practice. Of those in active practice, 68 percent worked full-time and 32% worked part-time. Approximately 23 percent were not employed in nursing and were not looking for nursing employment. Three percent or about 43,000 were actually seeking employment, a figure which is well within the "frictional unemployment" range. About 4 percent or 56,780 nurses were employed in other fields. Through the same survey, it was learned that about 25 percent of those not employed were pursuing further education.

The Administration has suggested that the reason for the nursing shortage is the inactive pool of licensed registered nurses. We believe it is unrealistic to expect much assistance from this group for a variety of reasons, since most of those who are inactive appear to have legitimate reasons for this status.

The presence of young children is probably the primary reason for a change to inactive status. 146,083 nurses or 34.5 percent of those nurses who are inactive have children under the age of 17. Nurses of child bearing age have a greater tendency to drop out of the work force and return later as their children mature. The 1977 survey showed a decrease in activity rates for nurses with children under the age of six and a concommitment increase for those with children ages 6 - 17. More than 1/3 of the total inactive nurse work force represent individuals over the age of 50. With increased complexities of technological nursing care it can be expected that the nurse over the age of 50 may not be able to cope with the stress and physical fatigue inherent in modern acute care nursing.

The most current discussion of the required Federal role in resolving nursing supply problems speaks solely to "numbers." However, the National League for Nursing is also concerned with the impact of insufficient Federal financial assistance on the ability of schools of nursing to achieve an optimal level of quality in the preparation of individual nursing students. This preparation includes both theoretical and clinical components, and is dependent on adequate numbers of teachers, administrators, and other supportive personnel, modern physical plants (e.g., classrooms, laboratories, and libraries), and a stable financial base that allows for needed flexibility in integrating the latest concepts in nursing education and patterns of care. The Administration's proposed elimination of what is presently 10 percent of a nursing school's annual budget will place a school in the difficult position of combating inflationary pressures and replacing a large portion of their fiscal resources.

Institutional support to schools of nursing has provided funds for recruitment of students as well as remedial programs for disadvantaged students. The cutbacks that schools have experienced in capitation have already been reflected in a decrease in remedial program activities. Talented students are now being recruited to other professional schools, such as business, engineering, and law.

There are serious categorical shortages of nurses as well, and perhaps, the most serious problem of all is the dearth of nurses in leadership positions. Presently, there is a shortage of clinical specialists, teachers, researchers, and administrators for service agencies, educational institutions, and government. During the next decade, an increase in demand for these highly specialized workers is projected. For instance, the demand for nurses with advanced training in community mental health is predicted to increase by 40% during this period. Advanced medical technology has resulted in the need for more highly skilled nurses, who are educated to provide leadership in patient care settings as diverse as infants in high risk nurseries and elderly patients in nursing homes. Clinical nurse specialists are being educated in advanced nurse training programs to assume the responsibility for developing a plan of care over a twenty-four hour period, demonstrating care to other nursing personnel, and providing health teaching and counseling to patients and families. In the near future nurses will need such skills as computer proficiency and scientific and mathematical sophistication to adjust to rapidly changing technologies in hospital settings.

Currently, over 800 budgeted faculty positions are vacant in educational programs preparing registered nurses. Between 1976 and 1978, there was a 3 percent increase in unfilled faculty positions. Among faculty teaching in all three types of programs which prepare registered nurses, only 58 percent of the faculty is prepared at the minimal or master's level, with under five percent of all faculty having doctoral preparation. Among directors of nursing services, a large proportion only have a basic diploma preparation. Only 25 percent have a baccalaureate degree and even fewer have graduate level preparation, yet these same individuals are responsible for large personnel budgets and significant policy decisions within health care agencies.

Federal funds allocated for advanced nurse training programs, currently support about 82 programs in a variety of specialists areas, such as parent-child nursing, epidemiology, burn trauma, emergency care, gerontology, rehabilitation, midwifery, community health, oncology (cancer), critical care and primary care. These funds help schools of nursing to initiate new programs of study, extend current program capabilities and contribute to the development of new knowledge in nursing and patient care. These monies also strengthen the institution of higher education's ability to provide quality training for advanced nursing practice, teaching and administration.

To maintain the quality of direct patient care demands, more nurses require more student financial aid and better educated faculty. Other educational fields learned long ago the value of having students taught by individuals with advanced degrees, prepared to assist them in the synthesis of knowledge. This is especially true for nursing, in view of the day-to-day judgments being made by nurses that affect so many lives.

The number of graduates with advanced preparation in a clinical specialty has greatly increased in the past ten years. In 1968, 3% of all graduate students elected advanced clinical practice, while in 1977, 75 percent of all graduate nurses enrolled in clinical practice programs. Although the total enrollment of graduate students has risen dramatically in the last decade, one must also recognize that many more students are enrolled on a part-time basis. Thus, the total number of graduates from master's and doctoral programs has not increased at an adequate rate. If traineeships and fellowships for nurses seeking advanced training are curtailed, the resulting decrease in the number of graduate students will have a deleterious effect upon our health care system.

Assuming full-time study for two years, the average young person faces a cost of tuition and living expenses of $12- $15,000, in addition to a loss of income for that period. At the same time, salaries for most nursing positions have been notoriously low. Clinical nurse specialists can anticipate an average salary of about $16,000 - $18,000 yearly. The salary expenditure curve in nursing is very flat and has a poor salary progression. At an expected salary range of $16,000 - $18,000, a young person who seeks to borrow for graduate education will find a relatively few low-cost options available, and the availability of commercial loans is generally based on one's current or future earning power. We believe the costs of Advanced Nurse Training and traineeships present a serious dilemma which will mitigate against the future benefits of improved health care if students do not receive Federal assistance. Graduate trained nurses represent a national resource and as such ought to have high priority in Federal funding for nursing. Scholarships for exceptionally needy students would complement minority recruitment and retention activities as well as reduce financial hardships for students unable to secure adequate financial aid from other Federal student assistance programs.

In addition, the current nursing loan program, with its loan forgiveness provision, can serve to encourage nurses to practice in shortage areas. If this program is dropped, we will lose another low cost incentive to provide for better geographic distribution of nurses.

Loss of traineeship, scholarship and nursing loan funds will surely exacerbate the already significant decline in enrollments, especially at the advanced nurse training level. This will ultimately lead to a shortage of qualified faculty prepared to teach basic nursing skills, as well as a shortage of advanced clinicians and practitioners who are being prepared to deliver cost effective health care services.

The health of Americans and the health financing responsibility of the Federal Government can benefit from nursing research produced by doctorally prepared nurses. Little attention has been devoted to mobilizing the knowledge and abilities of nurses, which is the largest group of specially trained providers in developing and implementing reform from within the system. Research-based changes in nursing care may lead to savings at least as great as those produced by utilization review. In addition, research-based emphasis on home health care built on nursing services can achieve change but avoid the burdens of new regulations or legislative changes.

Sixteen universities now award doctoral degrees in nursing but these 16 are graduating fewer doctorally prepared nurses this year than five years ago, when there were only nine doctoral programs. Although enrollments in doctoral programs have continued to rise, the large number of part-time students has prolonged the completion time for this degree. Pre-doctoral National Research Service Awards currently support only 119 fellows. In many doctoral programs this is the only form of student assistance available for full-time students. Total funding for Nursing Research has been at a $6 million level for the last four years. (In contrast, this year's budget for NIH is over $3 billion!) The benefits that have been demonstrated from nursing research merit expanded support, especially in those areas targeted to cost-effective clinical care.

Nursing makes a unique contribution that has been long neglected both within nursing and the Federal Government. Health is a major concern for most of the nation's taxpayers. Health care has become the third largest industry in the United States and is growing rapidly. Registered nurses constitute the largest group of health professions and yet are grossly under-represented in most Federal and State health policy and planning councils. Now that nursing has a growing capability to contribute research data to health care policy on a national level, we urge that nurses be appointed to more national health policy-making councils.

We turn now to your distinguished Subcommittee, as we have in the past, to intervene. In recent years, this Subcommittee has demonstrated a sensitivity to the nursing profession, and the needs of nurse training programs.

The evidence that an adequate supply of nurses can only be achieved by continued Federal Support has shifted further in the past year toward full justification of the continuation and expansion of funds to Nurse Training programs. The Subcommittee has recognized the facts in previous years and has continued to recommend policy approaches that have the potential to alleviate the root causes of present nursing problems. We applaud the Subcommittee, and staff, for considering the Nurse Education proposal. And, Congressman Waxman is to be commended for his diligent efforts to insure that the Nurse Training and other Health Manpower authorizations are expeditiously extended by this Subcommittee.

In general, we find the proposal to be a comprehensive and rational approach to existing crisis conditions. The continuation of institutional support through baseline levels of Federal financial support to nursing schools is a critical element in resolving present problems. Without this subsistence level of basic support, many of the nursing programs in our country would face financial hardships so severe that the viability of their continued existence would be open to question.

We are especially pleased with the inclusion of a career mobility program as one of the conditions for the receipt of institutional funds. Many nurses who wish to continue their education are heads of single-parent families or are middle-aged women who lack the financial resources to do so. In addition, allowing part-time equivalents to be counted in the institutions' enrollment figures will be of great assistance in alleviating the fiscal burdens that schools presently face. This change in the current law is surely an essential and justifiable one, given the fact that part-time students assume their fair share of institutional expenditures.

We do have some concerns regarding the proposed decreased level of support per student enrollee from $400 to $200 in collegiate schools of nursing. We feel that this decrease will be very detrimental to institutions of higher education, particularly because the decrease occurs at a time when these institutions face financial distress due to the withdrawal of a variety of other funding sources.

We also strongly believe that the continuation of a nursing scholarship program, due to its potential to attract new nursing students from an ever-declining pool of eligible high school graduates, is essential to insure an adequate supply of nurses in the future. Therefore, we respectfully request that the Subcommittee give serious reconsideration to the possibility of retaining this vital program. Although we are satisfied with the proposal's provision of very reasonable interest rates in the loan program, we feel that the high cost of nursing education requires additional inducements with which to attract the most qualified students. As a program which fosters the entry of individuals from disadvantaged backgrounds into the nursing profession, nursing scholarships would also be a very key program in correcting the inadequate current level of minority representation in the nursing field.

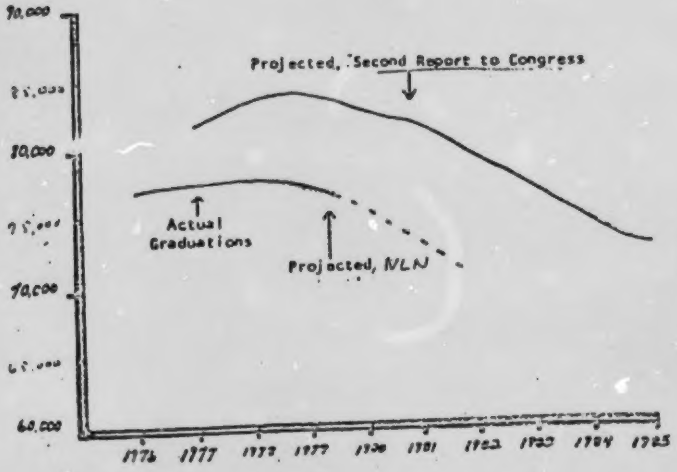
We are very pleased that the Advanced Nurse Training authority has been retained since funding for these programs is our highest priority. Graduates of these programs will alleviate the very serious shortage of nurses in leadership positions, which include administrators, clinical nurse specialists, teachers and researchers.

Finally, the continuation of programs of support for Nurse Practitioner Training and Special Projects preserve viable mechanisms through which the Nation's nursing supply and distribution problems can continue to be addressed.

Thank you for affording me the opportunity to appear on behalf of the National League for Nursing and the millions of patients served by our members.

Figure I

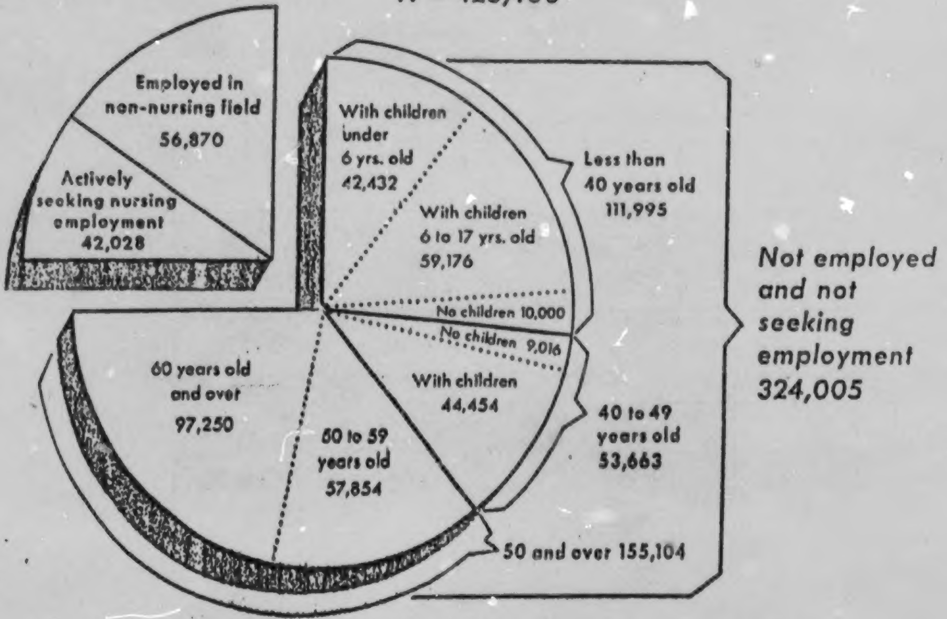
Graduations from Registered Nurse Education Programs, Actual, and Projected to 1985



Source of Projections - Second Report to Congress, Nurse Training Act of 1975

Source of Actual - NLN Surveys of RN Schools of Nursing

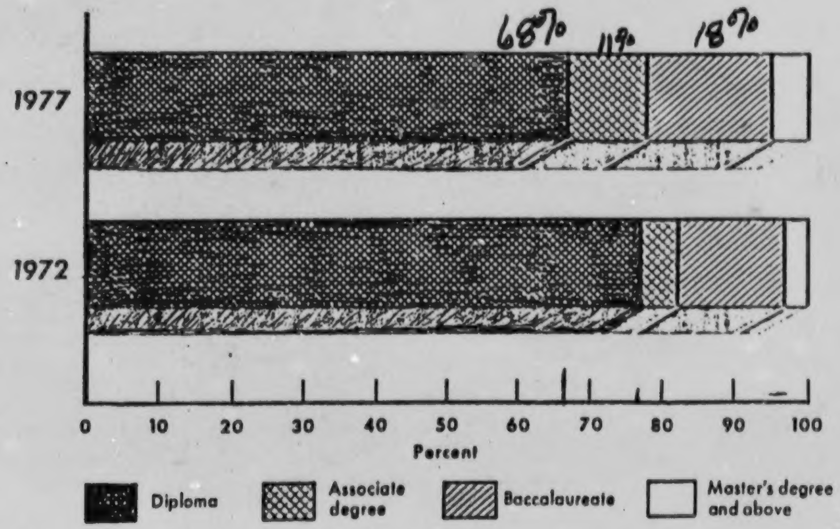
CHARACTERISTICS OF REGISTERED NURSES NOT EMPLOYED IN NURSING
September 1977
N = 423,400



Source: *1977 National Sample Survey of Registered Nurses*

Figure 4

ESTIMATED PERCENT* OF REGISTERED NURSES BY HIGHEST NURSING-RELATED EDUCATIONAL PREPARATION, 1972 and 1977



* Adjusted for nonresponse to highest nursing-related educational preparation.

Source: *1977 National Sample Survey of Registered Nurses*
A Report on the Nurse Population and Factors Affecting their Supply

CHART 6

NURSING IN THE MASS MEDIA RESEARCH PROJECT
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THE UNIVERSITY OF MICHIGAN

EVIDENCE SUBSTANTIATING THE ESCALATING SHORTAGE OF REGISTERED NURSES AS REPORTED BY THE NATION'S PRESS, SEPTEMBER, 1979-FEBRUARY, 1980

Dramatic documentation for a shortage of nurses in the United States can be found in a review of recent newspaper articles on the subject. Headlines offering generous bounties leading to the hiring of a qualified nurse are common. (Indianapolis Star, 14 October 1979; Carson City, Nevada Appeal; 18 October 1979; Austin, Texas, Citizen, 15 Octob[illegible] 1979.) Small town weeklies and big city dailies have devoted an increa[illegible]unt of attention to the nursing manpower shortage that threatens h[illegible]re in their communities. Approximately 1,200 articles on the nurse shortage appeared in U.S. newspapers in the six month period between September, 1979 and February, 1980. Newspaper articles on the nursing shortage have increased by nearly 300% compared to the number of articles found in the same time period one year ago. The evidence of a national shortage of nurses emerged spontaneously in communities all over the country; these articles offer a rather different picture of the issue than that being given by the Carter administration. Administration statisticians and officials have concluded that there is no nursing shortage and that there will be an ample supply in the forseeable future. Based upon its unfounded conclusions, the administration has determined to reduce nurse training funds by 75% in the coming year.

According to the articles reviewed, the geography of the nurse shortage has changed markedly in a short time. Last year, the states of California, Texas, and Florida -- areas of great population growth -- reported the existence of a crisis in nursing manpower. The crisis in these states has only escalated in the past year. This year, major cities in the midwest and along the eastern seaboard, not long ago a source of surplus nurses, are now experiencing critical shortages of nurses. Indiana, Illinois, Utah, Maryland, Massachusetts, Minnesota, Missouri, Michigan, Wisconsin, Ohio, and Pennsylvania have recognized the nursing shortage as a matter of both state-wide and national proportions. Especially hard hit have been certain large cities: Chicago, Minneapolis, Detroit, Baltimore, and Philadelphia. In Chicago alone, there are an estimated 2,000 budgeted nursing positions that cannot be filled. On a national basis, there are 100,000 vacant nursing jobs.

A widely circulated review of the nursing shortage written by Patricia McCormack of UPI prompted many local newspapers to review their own nursing manpower situation. All reported concurrence with the UPI assertion that "The nation may be in the biggest nursing shortage ever." (San Jose, California, San Jose Mercury, 1 October 1979; Winston-Salem, N.C., Journal, 30 September 1979; Fort Wayne, Indiana, The Journal-Gazette, 30 October 1979; Rochester, N.Y., The Democrat and Chronicle, 23 September 1979.) The nursing shortage affects big metropolitan areas, rural areas, public hospitals and private ones, the East, the West, the South and the North. Finding qualified nurses is no longer the problem only of poor or isolated regions, but has become the headache and worry of hospital administrators and physicians all over the country. Nurse recruitment has become a permanent administrative problem for hospitals and nursing homes, and professional nurse recruiters have been hired to ease the problem.

Almost every newspaper article on the nursing shortage offered a variety of explanations for the disturbing news that there are not enough nurses to provide the kind of care expected in modern hospitals. Nurses most often cite the lack of adequate financial compensation and the unfavorable working conditions imposed upon hospital nurses. Denver nurses found that the apprentice checkers at their local supermarkets were earning more money per hour than experienced registered nurses. (Rocky Mountain News, 27 September 1979.) One nurse noted, "If I, a college-educated nurse, get $6 or $7 an hour, and the guy who puts on the hubcaps in a factory gets nearly double -- well -- it's a crime." (Chicago Tribune, 14 October 1979.) Perhaps even more troubling to nurses than money are the conditions of working in a hospital, especially if the hospital is already understaffed. In addition to the undesirable aspects of hospital work, such as weekend work and a grueling rotation schedule, nurses point out that there is no incentive to remain a working nurse. There is no place for a talented and ambitious nurse to go in a hospital, if she wants to remain in patient care. If a nurse wants to advance in her profession and to earn more money, she must quit patient care in favor of administration or teaching.

Finally, in a growing number of understaffed hospitals, even more nurses quit when they can no longer tolerate working 12- and 16- hour shifts and knowing that their patients are not receiving good care. All of these issues contribute to the huge turnover problem in nursing: California reports a 30-50% turnover in nursing positions every year, which costs, in terms of recruitment and training, $187 million dollars a year.

Certain irreversible social and technological changes have also contributed to the nursing shortage. The women's movement has opened the door to traditionally male careers such as medicine and the law. The "new breed of nurse" with a college education and a new degree of self-confidence will not accept perceived deplorable conditions imposed by hospital regimens. New opportunities for nurses outside the hospital have drawn many nurses into independent or expanded roles. Advances in surgical techniques and medical technology have created a huge demand for nurses with special training: coronary care units, renal dialysis units, and burn centers require intensive and experienced nursing if the patients are to benefit from the medical advances.

Yet if everyone has an explanation for the nursing shortage, almost no one has offered a solution for the problem. The only consistent answers have been costly, short-term "Band-aid" remedies that attempt to stave off crisis for a few more months. Flashy recruitment campaigns are common procedures. Some estimates suggest that it costs between $7,000 and $8,000 to recruit a nurse; and hospital administrators consider the money well-spent if the nurse stays for only two years. In addition to bounties ranging from $100 to $1,000 per recruited nurse, hospitals pay for national and local advertisements, trips to recruit nurses from other areas, and they offer to find and subsidize housing for nurses who accept jobs in distant cities. None of these efforts have been too successful. It is reported that Filipino nurses brought to the U.S. at great expense, especially in California and Florida, do not remain for long and experience serious cultural and language problems during their short tenures.

Temporary nurses fill up to 20% of nursing positions in some hospitals.

Concurrently, temporary nursing employment agencies reap a hefty profit from providing nurses to beleaguered hospitals at a very high rate. Staff nurses at hospitals, not surprisingly,resent the presence of these temporary nurses who earn considerably more per hour than they do and yet assume none of the major burdens of patient care such as the paperwork. Furthermore, there is no way that temporary nurses can be trained in hospital emergency procedures -- leaving open the possibility of serious deficiencies in safety standards. (Los Angeles Times, 2 December 1979.)

The high monetary cost of the nursing shortage is paid for by patients. But patients also pay another cost, potentially higher, in the quality of care they receive. Administrators insist that despite the 10-20% nursing vacancies in their hospitals, patient care is not jeopardized. Nurses and physicians tell another story. At best, an understaffed nursing service means that the nurse has no time for the other essentials such as offering emotional support and education for her patients. At worst, the nursing shortage means that patients go without needed supervision, which occasionally leads to unnecessary complications. One Florida physician summed up the situation in his hospital, "We are not providing what we say we are -- quality care." (Daytona, News, 15 January 1980.) Closing down beds and limiting admission has meant that doctors often must postpone admitting patients in need of care or surgery. (Yucca Valley, California, Hi-Desert Star, 30 January 1980, Portland, Oregon Journal, 7 February 1980, Waukegon, Ill, News-Sun, 7 September 1979.) A Minneapolis nurse recounted her nightmares coming true when she found herself making mistakes in patient care because of the number and severity of patients in her charge. (Minneapolis Tribune, 3 December 1979.)

The prognosis for nursing manpower is not optimistic. Despite the

President's assurance that the matter is well in hand , experts recognize a different trend. First, in addition to the current decline in nursing school admissions, there is the simple matter of a declining birth rate which means fewer young women will be entering the employment market. Second, all indications are that there will be an ever-increasing need for registered nurses in the coming decades, estimated as some 240,000 more nurses needed by 1985 according to the Department of Labor. The growing percentage of elderly in the population, with accompanying acute and chronic health care needs, demands the expansion of health care services. The continuing improvements in health technology also require an expanding pool of skilled and experienced nurses to monitor and use this equipment. (Baltimore Evening Sun, 1 November 1979.) The manpower needs of a possible national health program have never been adequately addressed.

These newspaper articles eloquently testify to the existence of a severe nursing shortage in the country. As yet there has been no scientific study of the parameters of the issue, no systematic research into the contributing factors of the nursing shortage. It remains something of a mystery how the President can recommend nearly terminating aid to nurses training without any serious effort to understand the dimensions of the current problem or to face the future crisis in nursing manpower. There has been no grass-roots support for the President's proposal; virtually all local newspapers negatively criticize the President's proposed cut-back in articles establishing the nursing shortage in their cities. Even the most cursory review of these articles leads the reader to doubt the widsom of the President's proposal and to hope that Congress will undertake to prevent the President from intensifying an already critical shortage of nurses in the United States.

Senator **Metzenbaum**. Thank you very much, Dr. Davis. We will be happy to have both of your charts.

Dr. Rose Chioni.

Dr. **Chioni**. The American Association of Colleges of Nursing wishes to thank and congratulate the committee for its very important work. We wish to affirm the merit of a partnership relation between the Federal Government and the schools of health professions. Federal support for a comprehensive analysis of health manpower needs will enable individual schools of the health professions to establish appropriate academic priorities and to work with the Congress in developing and implementing a health manpower policy.

My remarks, however, will highlight that section of the manpower bill which specifically addresses the education of nurses.

I am Rose M. Chioni, Ph. D., R.N., dean, School of Nursing, University of Virginia, and president, American Association of Colleges of Nursing.

The American Association of Colleges of Nursing represents 250 nursing programs located in senior colleges and universities in the United States. I am proud to report that the collegiate schools of nursing represented within the American Association of Colleges of Nursing recognize the need to facilitate the educational mobility of the practicing nurse.

We enthusiastically endorse the attention which the Congress has given to the Health Professions Training and Distribution Act of 1980:

First, to provide an educational refreshment and enrichment for the nurse who has been inactive;

Second, to encourage baccalaureate programs to admit graduates from associate degree programs or hospital schools of nursing;

Third, to make part-time study a realistic educational option for students;

Fourth, to recruit and retain students from minority and disadvantaged groups;

Fifth, to make educational opportunities available to the student or practicing nurse within his/her community of residence;

Sixth, to extend service scholarships to those who practice in underserved areas.

The American Association of Colleges of Nursing recognizes that the support of the Federal Government for students of nursing has been significant. Nursing is predominantly a woman's profession. The availability of low-interest loans, scholarships, and the support for advanced training has made it possible for nursing students to pursue their education. Loss of or a radical change in this support would decrease the numbers of nurses available to meet the health needs of the American public and/or delay their entry into practice.

Advanced nurse training programs are in desperate need of Federal support. Approximately 4 to 5 percent of the total active nurse force has completed graduate study in nursing. From this small group come nurse administrators, teachers, clinical nurse specialists and nurse researchers. Nurses who have completed graduate preparation in nursing are truly a national resource. Augmentation of their small numbers can be regarded as a Federal responsibility.

It is for this reason that we make a strong statement in support of continuing the traineeship program for advanced nurse training. Failure to provide support through traineeships will occasion a serious decrease in teachers, administrators, specialists and researchers. The nurses give leadership to the partnership with the Federal Government.

We particularly appreciate the members of this subcommittee for the options and incentives, through priority grant and special project programs, which they have given to schools of nursing. We share the subcommittee's concern about the need for increasing and enriching clinical education for nursing students.

We grieve with you about the shortage of nurses occasioned by rapid turnover within hospitals. The members of the American Association of Colleges of Nursing look forward to the development of demonstration projects which can lead to the identification and remediation of the factors which occasion the rapid turnover and alleged exodus of nurses from practice.

Thank you for your continuing interest in nursing.

Senator **Metzenbaum**. Thank you, Dr. Chioni.

Russell Perry, Trenton State College, representing the National Student Nurses' Association.

Happy to have you with us this morning.

Mr. **Perry**. Mr. Chairman and Senator Schweiker, the National Student Nurses' Association is pleased to have this opportunity to present testimony in support of the Nurse Training Amendments of 1980. NSNA is the 35,000-member organization for undergraduate students of nursing.

I am Russell Perry, a nursing student at Trenton State College in New Jersey, and a member of the NSNA board of directors. My verbal presentation will be brief, in the interest of time, but I would ask that you put our extensive statement in the record.

Senator **Metzenbaum**. It will be included.

Mr. **Perry**. In this statement, we wish to focus on Nurse Training Act assistance to undergraduates as well as the National Health Service Corps.

INSTITUTIONAL SUPPORT

Tuition costs to students have been rising sharply in the past few years. However, tuition alone is not enough to cover the operating costs of an educational institution. Inclusion in the Nurse Training Act of an institutional support mechanism for schools meeting specified enrollment objectives or educational priorities would assist the schools as well as helping meet national health needs.

STUDENT LOANS

Loans have become the primary method for nursing students to finance their educational costs. A 1979 survey of members by NSNA showed that 52-percent surveyed received some type of Federal financial aid.

Eighty-four percent of the students receiving Federal aid stated that they could not continue school without that assistance. Nursing students are in an unusual situation as far as financial aid is concerned. The cost of nursing education is higher than that of a liberal arts candidate because of clinical laboratory costs, uniforms, and higher tuition due to increased costs to the educational institution.

In the NSNA survey cited above, 54 percent of the total respondents indicated that they paid $2,000 or more for their education per year. The situation of minority students is one of particular concern to NSNA. Minority enrollments are dropping. The December 1979 Health Resources News cites distribution of 1974 nurse training scholarships and loans. The distribution is far higher among minority students than their actual representation in nursing education programs, indicating proportionally greater need.

The recent creation of a separate cabinet-level Department of Education has created some speculation that undergraduate nursing students' assistance should come under this new department with other undergraduate students.

We feel that undergraduate nursing assistance should remain a priority in the Nurse Training Act. Continuity between undergraduate nursing student assistance and other provisions of the act is important, to avoid further dilution of Federal nurse training incentives.

Of course, NSNA realizes that Federal financial assistance to nursing students carries an expectation that the recipients will use their educational preparation to meet national health priorities and needs.

In the NSNA survey, 72 percent of the students receiving Federal assistance said that they would be willing to practice in an underserved area as an option to repay a Federal loan. Nursing students are not asking for a free education at Government expense; we are asking for help to complete our nursing education so that we may enter into active nursing practice.

SCHOLARSHIP GRANTS

There are students with exceptional financial need for whom the burden of debt resulting from large amounts of nursing student loans is prohibitive. Scholarship grants enable qualified students in financial distress to complete their education when it would otherwise be impossible.

NATIONAL HEALTH SERVICE CORPS

For the 1979–80 year, 80 NHSC scholarships were available to baccalaureate nursing students, while 620 applications were received. Nursing students wish to participate to a greater extent than scholarships are available.

The National Health Service Corps has just begun placement of health providers other than physicians in underserved areas. These providers may prove to be more cost effective, but more time is needed to realistically evaluate this.

We urge the continuation of the National Health Service Corps scholarship program. In addition, we ask that consideration be given to increasing the number of awards available to baccalaureate nursing students.

NSNA feels that continued Federal support to nursing education through the Nurse Training Act is vital.

Thank you.

[The prepared statement of Mr. Perry follows:]

STATEMENT

ON

NURSE TRAINING AMENDMENTS OF 1980

FOR THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESOURCES

By the

National Student Nurses' Association, Inc.
10 Columbus Circle
New York, New York 10019

Wednesday, March 12, 1980

Presented by: Russell Perry
Nursing Student
Trenton State College
Trenton, New Jersey

The National Student Nurses' Association is pleased to have this opportunity to present this statement in support of the Nurse Training Amendments of 1980. NSNA is the 35,000 member organization for undergraduate students of nursing.

Now more than ever, nursing education stands in need of federal support for its continuation and improvement. There has been a great deal of controversy recently about whether or not there is a nursing shortage. (An Institute of Medicine study is in progress on this subject). However, it cannot be denied that there is a shortage of nurses practicing in underserved areas and in certain specialty areas. The Nurse Training Act can help provide some remedies for this situation by increasing the nurses' preparation and incentives for practice in these areas.

The National Student Nurses' Association clearly recognizes the spending restraints all of us, including Congress, are living with. Current expenditure of public funds must be conservative and produce provable, cost-effective results. We feel that the Nurse Training Act can provide for preparation of competent nurses who can work in underserved areas and specialty areas, to provide more health care to the general population at lower cost than some other health professionals.

In this statement we wish to address the general areas of the Nurse Training Act, particularly assistance to students, as well as the National Health Service Corps.

Institutional Support

Tuition costs to students have been rising sharply in the past few years. However, tuition alone is not enough to cover the operating costs of an educational institution. Other sources of funds for nursing educational programs, such as private philanthropy, are decreasing as reliable alternative sources of income. Schools of nursing who wish to undertake innovative programs and enrollment activities need a source of financial support. Inclusion in the Nurse Training Act of an institutional support mechanism for schools meeting specified enrollment objectives or educational priorities would assist the schools as well as helping meet national health needs. Of particular importance is institutional support aimed at an increase in the number of B.S.N. programs available to graduates of diploma and associate degree nursing programs, an increase in the number of graduates of nursing education programs who practice in underserved areas, and an increase in representation of minority/disadvantaged groups.

Statistics indicate that admissions, enrollments, and graduations of blacks and men in basic nursing programs have decreased between 1975 and 1978. The proportion of blacks admitted in 1975 was nine and one tenth percent, in 1978, seven and two tenths percent. Enrollment and graduation fugures have declined similarly. (National League for Nursing, Data Digest, Update on Nursing Education, 1979)

Special Projects Grants

This provision has provided funds for nursing education programs to undertake projects to increase the numbers of minority students in nursing and also for innovative educational programs for both formal and for continuing education. It has encouraged creative concepts to be initiated and evaluated in nursing education. We urge its continuation.

Advanced Nurse Training

The health field is desperately in need of nurses prepared at the graduate level. Presently, approximately four percent of nurses are prepared at the master's or doctoral level. Many geographic areas simply do not have graduate nursing education programs available. These programs are the source of nurse educators, administrators and nurse clinicians, many of whom are prepared in primary as well as acute care settings. As an undergraduate student association, we strongly see the need for competent, qualified nurse faculty members to educate today's undergraduate nursing students. The need for nurses with administrative and supervisory preparation is also acute.

Nurse Practitioner Programs

This, in the past, provided for preparation of nurse practitioners with an emphasis on primary health care in geographically underserved areas. The nurse practitioner is able to practice in sites without full time physicians, thus providing a source of primary health care to underserved populations. No specific cost data is available, but education of a nurse practitioner is less expensive than that of physician preparation, although the scope of practice does differ.

ASSISTANCE TO NURSING STUDENTS

Traineeships for Advanced Nurse Training

As stated above, the need for nurses prepared at the master's and doctoral level as educators, administrators, and primary care clinicians is acute. Many nurses currently enrolled in or planning to enter these educational programs are at midcareer, when it is extremely difficult to cease full time professional employment and enter on a further educational preparation program, both financially and personally. These individuals need financial support, and are ineligible for the bulk of state and private financial aid resources.

Student Loans

For the 1978-79 school year, the nursing student loan program was used by approximately 1,189 nursing education programs with 26,180 students participating. Loans have become the primary method for nursing students to finance their educational costs. A 1979 survey of members by the National Student Nurses' Association showed that fifty-two percent surveyed received some type of federal financial aid. Of those receiving federal aid, forty-five percent, or almost half, were recipients of federal nursing student loans. Eighty-four percent of the students receiving federal aid stated that they could not continue school without that assistance.

Nursing students are in an unusual situation as far as financial aid is concerned. Most nursing education programs that prepare a student for initial licensure as an RN take place at the undergraduate level, in an associate degree, baccalureate, or diploma program. This is in contrast to the health professions whose initial preparation is at the graduate level. However, even though they are undergraduates, the cost of nursing education is higher than that of a liberal arts candidate because of clinical laboratory costs, uniforms, and higher tuition due to increased costs to the educational institution. In the NSNA survey cited above, fifty-four percent of the total respondents indicated that they paid $2000 or more for their of education per year. In fact, twenty percent were paying $3500 or more to meet the cost of their nursing education. The survey also showed that fifty percent of the respondents came from families with incomes below $15,000 per year, and fifty-four percent were working 16 hours or more per week in addition to going to school to meet tuition costs.

The situation of minority students is one of particular concern to NSNA. For many years, we carried out a minority recruitment project under Division of Nursing special project funding. However, minority enrollments are dropping. The December 1979 Health Resources News (Vol. 6, #11) cites distribution of 1974 Nurse Training scholarships and loans. Of the scholarships, twenty percent went to black students, four percent to Hispanic students, and one and three tenths percent to American Indian and Asian students. Eighteen percent of the nursing student loans went to black students. The distribution is far higher than the minority students' actual representation in nursing education programs, indicating proportionally greater need.

The recent creation of a separate cabinet-level Department of Education has created some speculation and suggestion that undergraduate nursing students' assistance should come more under this department with other undergraduate students and that nursing students should make increased use of the Guaranteed Student Loan Program. This would create several problems. Under present regulations, nursing programs participating in the Nursing Student Loan Program cannot participate in the Guaranteed Student Loan Program. As already stated, the cost of nursing education is higher than the average. Additionally, nursing students cannot be equated with a basic liberal arts student, because they will be prepared to practice nursing upon graduation and licensure, meeting a national need. If the purpose of having a Nurse Training Act is to prepare nurses who can better meet U.S. health delivery needs, undergraduate nursing assistance should remain a priority in the Nurse Training Act. Continuity between undergraduate nursing student assistance and other provisions of the Act is important, to avoid further dilution of federal Nurse Training incentives.

Of course, NSNA realizes that federal financial assistance to nursing students carries an expectation that the recipients will use their educational preparation to meet national health priorities and needs. Loan forgiveness for service in a geographically underserved area or specialty area is one method by which this can be accomplished. In the NSNA survey, seventy-two percent of the students receiving federal assistance said that they would be willing to practice in an underserved area as an option to repay a federal loan. Preferential availability of loan money to students planning to practice in primary care areas, continue on for graduate education in nursing, or other specified national priorities is another option. Nursing students are not asking for a free education at government expense, we are asking for help to complete our nursing education and enter into active nursing practice.

Scholarship Grants

Most nursing students realize that student loans are the main mechanism they can expect to use to finance their education. However, there are students with exceptional financial need for whom the burden of debt resulting from large amounts of nursing student loans is prohibitive. Scholarship grants enable qualified students in financial distress to complete their education when it would otherwise be impossible. We urge the continuation of the scholarship grants.

National Health Service Corps

Only recently have National Health Service Corps scholarships been made available to baccalaureate nursing students. For the 1979-80 year, eighty NHSC scholarships were available to baccalaureate nursing students, while 620 applications were received. (Health Resources News, Vol. 6, No. 8, Sept. 1979) Obviously, nursing students wish to participate to a greater extent than scholarships are available.

The National Health Service Corps has just begun placement of health providers other than physicians in underserved areas. These providers may prove to be more cost effective, but more time is needed to realistically evaluate this. Sufficient time has not elapsed to determine whether the health professionals, especially nurses, will stay in these underserved areas once their service period has expired.

We urge the continuation of the National Health Service Corps scholarship program. In addition, we ask that consideration be given to increasing the number of awards available to baccalaureate nursing students.

Summary

The National Student Nurses' Association feels that continued federal support to nursing education through the

Nurse Training Act is vital. Since the emphasis has shifted from simply increasing the numbers of nurses to increasing the number of nurses prepared to practice in geographic or specialty underserved areas, the need is more acute. No one has yet found a guaranteed way to accomplish this, and nursing education programs and nursing students need financial support to explore new, more effective methods to meet the health problems of the U.S. in the most efficient and economic way. Nurses and nursing students recognize their obligation to society as members of the health delivery system. Our goals cannot be achieved, however, without some agreement on priorities and systematic support.

EMcG/sb
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Senator METZENBAUM. Thank you very much, Mr. Perry. We appreciate your comments.

Ms. Esiason, happy to have you with us this morning, representing the Federation of Nurses and Health Professionals, AFL-CIO.

Ms. ESIASON. I am here to represent the Federation of Nurses and Health Professionals and the American Federation of Teachers, AFL-CIO, an organization of over 550,000 teachers, paraprofessionals, nurses, and allied health professionals, all of which are directly concerned with the health care services in this country.

The health manpower proposals set forth before this committee attempt to address an extremely complicated set of problems. The problems of education, distribution, recruitment, retention, and utilization of nurses and other health professionals have become more acute as the cost of providing quality health care service increases. In nursing service alone, an article in "Nursing '79" indicates that 80 percent of hospitals in this country are experiencing nurse shortages.

Reflecting upon all the aforementioned problems and the concerns voiced by our membership, we submit the following summary comments on nurse education funding for your consideration:

DURATION AND FUNDING OF THE BILL

We ask the committee to consider a 5-year funding bill to stabilize funding and to have adequate time to thoroughly research the marketplace, collect and analyze data about the use of funds, distribution and retention of health professionals, and utilization of nurses and other health professionals already in the marketplace. We argue that a major cut in funding this year, on top of a 50-percent funding cut last year, totally disrupts the education and employment networks for nursing and other health professionals.

NATIONAL PRIORITY INCENTIVE GRANTS

Moneys provided for national priority incentive grants should be based, in both baccalaureate and associate degree programs on full-time and full-time equivalent students because of an increasing trend toward part-time education. With increases in the cost of education and in the cost of living itself, more and more students find it necessary to work and, therefore, cannot handle full-time enrollment.

New completely part-time associate degree programs are being created to meet the needs of these individuals and could not get funding without the addition of full-time equivalence in determining the enrollment in associate degree programs. This is extremely important, since part-time educational programs will meet the needs of minorities and disadvantaged individuals.

While we all may realize that this type of capitation support is unlikely to continue forever, we question this proposal which increases funding over the next 3 years. Why not start now with the higher level of funding—as proposed for fiscal year ending September 1983—and then decrease those funds by 10 percent each year to make an eventual phaseout of a less dramatic loss. There should also be a mechanism developed for accountability in the use of capitation funds so as to insure program enrichment rather than just support for administrative costs.

Availability of increased funding for special projects which provide for LPN's and RN's to continue their education is strongly supported. These men and women who return to school are highly motivated, have a tendency to stay in the workforce longer and are most likely to continue their education through the masters level and beyond which in turn helps meet critical needs for administrators, supervisors, educators, and researchers. Support for education to allow nurses to reenter practice is invaluable since technological change in the industry continues and these individuals need incentives to go beyond some of the reasons which cause nurses to leave practice, such as child rearing and poor working conditions.

We assert a strong belief that nursing education has consistently improved and that the quality and amount of supervised clinical practice has increased over the year, not decreased. We support any efforts aimed at further improvement of clinical practice.

For example, there are increasing opportunities for internships for graduate nurses which hopefully will address this goal.

To assure access to these programs, loan repayment deferrals should be available to nurses serving internships just as they are to other health professionals, including physicians. Loan repayment deferrals for these internships should be provided for nurses enrolled in programs offered by institutions of higher learning to make sure that they meet the needs of the students first and the service requirements of the health institutions second.

We urge continued funding for traineeships at their present levels. The shortage of qualified personnel for administrative, educational, and research positions remains acute. At my own college, three faculty positions were advertised for several months with only one marginally qualified applicant response. However, when 75 percent of all nurses in this country are below the baccalaureate level, there is an enormous need to increase their access to education and the number of nurses available for graduate study is limited.

Availability of loan forgiveness should be tied to length of time the nurse remains in practice as well as time served in areas of priority need for nursing care, both in State and out-of-State. The ability to repay the loan based on salary earned should also be considered.

While we support the concept of the National Service Corps in exchange for financial assistance, many who enter nursing studies will be unable to leave their home area for personal reasons. It has been demonstrated that providers indigenous to an area are better equipped to deal with the problems of that area and therefore availability of ij-State service should be added.

Nurse practitioners and nurse anesthetists often earn wages that are far in excess of the staff nurse and they are better able to repay these loans. Higher earning capability and loan availability should be incentive enough to encourage enrollment in nurse practitioner and nurse anesthetist programs. Competition for admission to these programs is great, which proves this point.

Grants available to schools of medicine, osteopathy, dentistry, and veterinary medicine, et cetera, which enable them to meet the cost of recruitment of women should also be available to schools of nursing to meet the cost of recruitment of both men and women. With 100,000 unfilled nursing jobs in this country and overall applications to nursing programs declining, we are apt to encounter greater shortages unless funding to support recruitment efforts is forthcoming.

Despite the statistical numbers game often discussed by the administration, the Bureau of Labor Statistics, and the Department of Health and Human Services regarding nurses, the facts in the marketplace reveal a shortage of practicing nurses. While the federation maintains a firm belief that programs of nurse retention are directly related to the need to control wages, benefits, working conditions and patient care through collective bargaining, we also recognize that without continued Federal support to correct utilization of nurses in the healthcare marketplace, there will always be a shortage of practicing nurses.

In conclusion, until the administration and the Federal Government recognize that physician services are only a small part of the health care picture, nurses and other health-care professionals will continue to receive less than adequate recognition.

We thank the committee for the opportunity to present our viewpoints.

Thank you.

[The prepared statement of Ms. Esiason follows:]

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ALBERT SHANKER
President

A SUMMARY STATEMENT BY THE
FEDERATION OF NURSES AND HEALTH PROFESSIONALS
AFT - AFL-CIO BEFORE THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES
U.S. SENATE

ON

NURSE EDUCATION AMENDMENTS
AND PROPOSED HEALTH PROFESSIONS
EDUCATION FUNDING

March 12, 1980

This statement was developed with the assistance of the Federation of Nurses and Health Professionals Education and Practice Committee.

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Louise Esiason is an assistant professor at Castleton State College in Vermont and is coordinator of the Associate Degree Nursing Program of that institution. She is a 1952 graduate of a 5 year baccalaurate program at the University of Maryland and completed a Master of Arts in Nursing Education at Teachers College, Columbia, New York in 1970. Over the years Louise has worked as a staff nurse in many settings, a supervisor, director of nurses, school nurse-teacher, and educator. She has been an institutional representative to the New England Council for Higher Education in Nursing for several years and served on their board of directors for one year.

I am here to represent the Federation of Nurses and Health Professionals and the American Federation of Teachers, AFL-CIO, an organization of over 550,000 teachers, paraprofessionals, nurses, and allied health professionals, all of whom are directly concerned with the health care services in this country. The following comments represent a summary of the Federation's full statement which will be forwarded to the committee for the record.

The health manpower proposals set forth before this committee attempt to address an extremely complicated set of problems. The problems of education, distribution, recruitment, retention, and utilization of nurses and other health professionals have become more accute as the cost of providing quality health care service increases. In nursing service alone, an article in *Nursing 79* indicates that 80% of hospitals in this country are experiencing nurse shortages.

Reflecting upon all the aforementioned problems and the concerns voiced by our membership, we submit the following summary comments on nurse education funding for your consideration:

Duration and Funding of the Bill

We ask the committee to consider a five year funding bill to stabilize funding and to have adequate time to throughly research the marketplace, collect and analyze data about the use of funds, distribution and retention of health professionals, and utilization of nurses and other heath professionals already in the marketplace. We argue that a major cut in funding this year on top of a 50% funding cut last year totally disrupts the education and employment networks for nursing and other health professionals.

National Priority Incentive Grants

Monies provided for National Priority Incentive Grants should be based, in both baccalaureate and associate degree programs on full-time and *full-time equivalent students* because of an increasing trend toward part-time education. With increases in the cost of education and in the cost of living itself, more and more students find it necessary to work and therefore cannot handle full-time enrollment. New completely part-time associate degree programs are being created to meet the needs of these individuals and could not get funding without the addition of full-time equivalence in determining the enrollment in associate degree programs. This is extremely important since part-time educational programs will meet the needs of minorities and disadvantaged individuals.

While we all may realize that this type of capitation support is unlikely to continue forever, we question this proposal which *increases* funding over the next three years. Why not start now with the *higher level* of funding (as proposed for fiscal year ending September 1983) and then decrease those funds by 10% each year to make an eventual phase-out of a less dramatic loss. There should also be a mechanism developed for accountability in the use of capitation funds so as insure program enrichment rather than just support for administrative costs.

Availability of increased funding for special projects which provide for LPNs and RNs to continue their education is strongly supported. These men and women who return to school are highly motivated, have a tendency to stay in the workforce longer and are most likely to continue their education through the masters level and beyond which in turn helps meet critical needs for administrators, supervisors, educators and researchers. Support for education to allow nurses to re-enter practice is invaluable since technological change in the industry continues and these individuals need incentives to go beyond some of the reasons which cause nurses to leave practice, such as child rearing and poor working conditions.

We assert a strong belief that nursing education has consistently improved, and that the quality and amount of supervised clinical practice has increased over the years, not decreased. We support any efforts aimed at further improvement of clinical practice. For example, there are increasing opportunities for internships for graduate nurses which, hopefully, will address this goal. To assure access to these programs, loan repayment deferals should be available to nurses serving internships just as they are to other health professionals, including physicians. Loan repayment deferals for these internships should be provided for nurses enrolled in programs offered by institutions of higher learning to make sure that they meet the needs of the students first and the service requirements of the health institutions second.

We urge continued funding of traineeships at their present levels. The shortage of qualified personnel for administrative, educational, and research positions remains accute. At my own college three faculty positions were advertised for several months with only one marginally quaiified applicant response. However, when 75% of all nurses in this country are below the baccalaureate level, there is an enormous need to increase their access to education and the number of nurses available for graduate study is limited.

Availability of loan forgiveness should be tied to length of time the nurse remains in practice as well as time served in areas of priority need for nursing care, both in state and out of state. The ability to repay the loan based on salary earned should also be considered. While we support the concept of the National Service Corp in exchange for financial assistance, many who enter nursing studies will be unable to leave their home area for personal reasons. It has been demonstrated that providers indigenous to an area are better equiped to deal with the problems of that area and therefore availability of in-state service should be added. Nurse practictioners and nurse anesthetists often earn wages that are far in excess of the staff nurse and they are better able to repay these loans. Higher earning capability and loan availability should be incentive enough to encourage enrollment in nurse practicitioner and nurse anesthetist programs. Competition for admission to these programs is great, which proves this point.

Grants available to schools of medicine, osteopathy, dentistry, and veterinary medicine, etc. which enable them to meet the cost of recruitment of women should also be available to schools of nursing to meet the cost of recruitment of both men and women. With 100,000 unfilled nursing jobs in this country and overall applications to nursing programs declining, we are apt to encounter greater shortages unless funding to support recruitment efforts is forthcoming.

Despite the statistical numbers game often discussed by the administration, the Bureau of Labor Statistics, and the Department of Health and Human Services regarding nurses, the facts in the marketplace reveal a shortage of practicing nurses. While the Federation maintains a firm belief that problems of nurse retention are directly related to the need to control wages, benefits, working conditions and patient care through collective bargaining, we also recognize that without continued federal support to correct utilization of nurses in the health care marketplace there will always be a shortage of practicing nurses.

In conclusion, until the Administration and the Federal Government recognize that physician services are only a small part of the health care picture, nurses and other health care professionals will continue to receive less than adequate recognition.

We thank the committee for the opportunity to present our viewpoints.

Thank you.

DATA COLLECTION AND ACCOUNTABILITY

Uniformity of efforts in developing comprehensive data on health manpower is fundamental to implementation of this nation's health planning policies. The federal government has every right to know how its dollars are being spent. Data collection which is centralized and comparable between schools, health care facilities, state and local governments and health planning agencies is a necessity if we are to determine ways to match available health resources with this country's relatively high unmet level of consumer needs for access to health care service.

While public educational institutions and public health care facilities have open reporting mechanism, the bulk of the health care industry is privately owned. Until the private sector of the health care industry jointly cooperates with the government, for specified collection of utilization, retention and economic data on health manpower, there can be no base for future judgement.

One deficiency the Federation recognizes in current data collection is lack of information on hospital work settings where over half of all nurses and allied health professionals are employed. One area of specific concern reflects retention problems of hospital-based health professionals.

The Federation suggests the Committee consider Federal support for a uniform data collection network operated through already existing health systems agencies. We feel that the HSAs are already looking at geographic distribution of health services, community health needs and appear to be the obvious clearinghouse for analyzing use of health manpower resources.

NATIONAL ADVISORY COUNCILS

The Federation supports cooperative efforts between the existing national advisory councils on education for nurses, other health professionals and graduate medical students. However, we also recognize that each advisory council has a unique role to play in the health planning process and therefore, should be allowed to exist separately in order to meet specific needs for those three areas of health manpower. We recommend that the name of the advisory council for nursing be changed to the National Advisory Council on Nurse Education and that membership on that council specifically include student nurses, AFL-CIO nurses and licensed practical nurses.

FOREIGN NURSE GRADUATES

Use of foreign nurse graduates by the hospital industry in this country does not answer the long standing and continued problem of nurse shortages. The influx of foreign nurse graduates erodes the existing nurse labor force in this country. In fact, the practice of using foreign nurse graduates denies employment to U.S. minority groups, promotes a subtle form of indentured servitude and comprises quality patient care. Use of foreign nurse graduates who have not met U.S. licensing standards is promulgated by vested interests who spend large amounts of money to recruit and import these nurses. If comparable resources were spent to improve present working conditions, hospitals would have no difficulty in finding U.S. qualified nurses for employment.

AREA HEALTH EDUCATION CENTERS

The continued support for development of AHECs is strongly supported by the Federation. It is our collective opinion that AHEC education programs which meet health care needs in rural areas should be expanded to also reflect growing needs in underserved urban areas. Further, the Federation believes strongly that AHECs present logical vehicle to greatly expand health education programs to citizens residing in a given AHEC region.

ALLIED HEALTH PROFESSIONALS

Federal grants to education programs for existing catagories of allied health professions should be continued at its previous level. While primary emphasis is with basic education programs among health professions, new incentives for programs which develop career ladders should be fostered. Health profession education programs, both at the community college and university level rather than in hospital based programs, will enhance development of a career ladder approach.

Senator **Metzenbaum**. Thank you very much.

I just have a couple of questions.

Why is there such a discrepancy between the administration's position that we have an adequate national supply of nurses, and your position on the subject as supported by the figures? Is the administration totally unaware of the failure of so many nurses to be actively engaged in the profession?

Dr. **Davis**. No, Senator. I believe that they are aware of our figures. We had a conference with them, and we shared this data base with them. So that they do have our actual figures.

Senator **Metzenbaum**. How do you account for their coming before our committee and indicating that there is an adequate supply; that there is no great need for additional nurses training?

Dr. **Davis**. It is very difficult for us to understand their position, because we have shared our data base with them. They continue to assume that the administration does direct them to make certain statements that are based on their priorities.

Senator **Metzenbaum**. Dr. Blakeney, what would be the impact of the administration's proposal on nursing?

Dr. **Blakeney**. We would see that as a substantial handicap. We applaud the administration's position of supporting the nurse practitioner, but there are so many other elements in nursing which need to be continued to support the needs for our society; so we see that as a marked handicap, the administration's emphasis on nurse practitioner programs to the exclusion of some of the other programs that we are advocating.

Senator **Metzenbaum**. Senator Schweiker?

Senator **Schweiker**. Dr. Blakeney, I gather from your statement and the charts, and Dr. Davis' statement too, that not only is there a declining curve in terms of nurses, but there is a long-range serious permanent shortage ahead of us?

Do both of you concur with that?

Dr. **Blakeney**. I would concur with that.

Dr. **Davis**. I certainly would concur. I believe we have adequate documentation. As a matter of fact, I would like to introduce for the record—this represents one-third of the clippings that have been pulled by a couple of our faculty at the University of Michigan, demonstrating the newspaper articles from September of 1979 through February, 1980, one-third of those.

We will prepare an abstract summary of those, but I can assure you they include almost all the States in this particular area.

Senator **Schweiker**. What do the newspaper articles say?

Dr. **Davis**. Makes statements about shortage of nurses. They indicate that there are coronary care beds being included, intensive care units being closed. Some hospitals now are in jeopardy of their JCH accreditation because of severe shortages in nursing.

Senator **Schweiker**. Thank you.

Dr. Chioni, the most critical shortage of nurses is the so-called bedside nurses. Yet, we in Congress have spent considerable moneys to stimulate advanced nurse training and nurse practitioner programs. I have been supportive of that.

My question is, what is your view of these programs and how do we respond to the need of attracting more bedside nurses?

Dr. **Chioni**. Senator Schweiker, you create a problem for me in terms of talking about bedside nurses. I think the practice of nursing is much broader than those who actually function at the bedside in the hospital. I think the moneys that have gone into the nurse practitioner programs and advanced nurse training programs have allowed us to prepare additional faculty and clinical specialists who function at a higher level in relation to direct patient care, and therefore will allow us to increase the opportunities for students at the beginning levels in nursing.

We believe that in relation to current shortages, that decreased moneys from advanced nursing training programs would only further compound the problems we are having in trying to educate those nurses needed for bedside nursing.

Senator **Schweiker**. Dr. Davis, what is the average tuition at each of the three types of nursing schools?

Dr. **Davis**. I am not certain I can give you at this moment, but I can introduce for the record the split between three types of programs.

Senator **Schweiker**. Give us a ballpark estimate and then we will let you supply the actual figures for the record.

Dr. **Davis**. I would say an estimate would range from a low in some of your community college programs depending, again, upon the base of support and tuition levels, from a couple hundred dollars per semester to a high in some programs in private institutions of about $7,000 a year. That is tuition only.

In addition to that, we would have to consider living expenses which range somewhere around $4,000 to $6,000 a year.

Senator **Schweiker**. What would hospital nurse education cost?

Dr. **Davis**. It is my understanding diploma programs have had to significantly increase their tuition also in the last decade.

Senator **Schweiker**. Where would you guess they would be?

Dr. **Davis**. I think the range is about $2,500 a year. I think it is around that average of $3,000 or so a year.

Senator **Schweiker**. Mr. Perry, one obvious way to offset a demographic trend that is confronting us, which shows a decrease in the pool of 18 year-old individuals available to apply for nursing school, is to interest more men in nursing.

As you heard in my opening statement, I encourage that. Of course, you are here representing them, and it looks like we won the ERA battle in nursing this morning anyway. We appreciate this.

My comment to you is: How can we attract men to this profession and what were some factors in your mind that made it appealing?

Mr. **Perry**. As you very well realize, being a male in society and being minority, this is a very unusual circumstance.

First of all, I think it must be pointed out that societal changes are being made not only for women, but for men, that can offer them a change and offer them increased participation in professions that were closed in the past.

The No. 1 societal change is that we are working in a field with expression of emotions and working in a caring program and this no longer takes away one's masculinity. That is one thing that must be pointed out.

No. 2, I think it is also important to point out that you are not only dealing with increasing numbers of men in the profession, but you are also increasing the care offered by the health care profession. Men and women sometimes look at things from a different perspective. An example of this—I have my own personal experiences—volunteering in an adolescent clinic where family planning was offered to females for approximately 3 years now, but they never offered it to males because they thought they would not be receptive to this.

After coming in and working in the clinic for 1 month, I might add, family planning has been added for males and is being utilized by males. This is just one example.

Another example is within the profession where men can be very helpful. There are many areas that are very touchy that men tend to shy away to discuss with females, such as sexual difficulties and propensity, and I think they have a right to have an integrated profession so that wholistic types of health care that should be offered in this country can be offered.

As far as incentives, loans and scholarships for both male and female is one of the ways to induce men to get into this profession.

That is all I can add at this time.

Senator **Schweiker**. Your earlier comments about loans and scholarships I noted with a great deal of interest. I think they are very helpful and we shall take them into consideration.

Senator **Metzenbaum**. Thank you very much.

Ms. **Esiason**. Could I add a comment about discrepancies between the Federal Government's position that there is no shortage and what we are telling you. I think part of the problem is the tremendous turnover in nurses every year. So many nurses leave the practice because of working conditions, family concerns, and so forth, that that is part of the problem.

Senator **Schweiker**. How do we solve that problem? I mentioned that in my opening statement.

Ms. **Esiason**. That is why I think the Federation of Nurses and Health Professionals came into being. We would like to get research to find out how to solve these problems, but a lot of it has to do with collective bargaining and improving working conditions through the collective bargaining process.

Senator **Metzenbaum**. Thank you very much.

The next panel is Dr. Walter Bowie and Mr. Raymond Gosselin.

STATEMENT OF DR. WALTER C. BOWIE, D.V.M., PH. D., DEAN, SCHOOL OF VETERINARY MEDICINE, TUSKEGEE INSTITUTE, REPRESENTING THE CONSORTIUM ON MINORITY HEALTH PROFESSIONAL SCHOOLS; AND RAYMOND A. GOSSELIN, PRESIDENT, MASSACHUSETTS COLLEGE OF PHARMACY & ALLIED HEALTH SCIENCES

Dr. **Bowie**. I am Walter C. Bowie, dean, School of Veterinary Medicine, Tuskegee Institute, Alabama.

Accompanying me at the table is Dr. Ralph Hines, provost and executive vice president of Meharry Medical College, Nashville, Tenn. We are representing the consortium of seven minority health professions schools, which includes Charles R. Drew Post Graduate Medical College; Morehouse College of Medicine; Florida

A. & M. University College of Pharmacy; Meharry Medical College; Texas Southern University College of Pharmacy; Tuskegee Institute School of Veterinary Medicine; and Xavier University College of Pharmacy.

An expanded consortium statement as well as individual university statements have been prepared and we wish to submit them to the committee for its record. However, the brief statement I will make is on behalf of the consortium.

The concerns which I bring before you are shared by all of us. Of paramount importance is the need for the Federal Government to provide assistance to insure that the high quality health personnel training taking place at our institutions will be strengthened and maintained.

Both the pending Health Professions Training and Distribution Act of 1980, S. 2375, and S. 2144, introduced by Senator Schweiker, have specific components which are critical to our institutions if we are to assist the Federal Government in achieving its goal of providing adequate health care to all Americans.

A major concern is the woefully inadequate number of underrepresented minorities in the health field and the need to improve significantly health care delivery services to the socioeconomically disadvantaged communities. The problem of underrepresentation is acute.

Only 1.7 percent of the physicians, 1.8 percent of the dentists, 2 percent of the pharmacists, and 1 percent of the veterinarians in this Nation are black. Over 50 percent of these pharmacists and 90 percent of these veterinarians are graduates of the traditionally black colleges. One school alone, Meharry Medical College, can account for 43 percent of the practicing black physicians and dentists in the United States today. These statistics substantiate the need for these schools and the Federal Government to maintain their partnership, if the problem of underrepresentation is to be addressed adequately.

We therefore propose that the following components be included in any new system of Federal financial support for health manpower training and subsequently in this testimony, make reference to those sections of S. 2375 as they impact upon our institutions:

First, we strongly support a national priority incentive grant program. Such an institutional support program undergirds the health professions schools in their efforts to keep the educational function, versus research and service, a major institutional priority.

Second, support is given to section 111, which proposes assistance to schools in acute or chronic financial distress. It is recommended, however, that section 111, which amends section 788(b), 2-A, be again amended to include the following substitute language:

> The Secretary may enter into cooperative agreements for not more than five years with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing or public health that are national priority institutions, as defined in subparagraph (c), to meet incurred or prospective costs of operation essential to remove such institutions from serious and long-standing financial instability, and if such an institution has previously received grant support under Section 788(b), as it existed prior to October 1, 1980; such an institution must agree to submit to the Secretary a plan providing for the institution to achieve financial solvency within five years and agree to carry out such a plan.

Third, the financial need and profile of students that are enrolled in the institutions of the consortium require student assistance due to their very limited financial resources. We, therefore, support sections 104 through 110 of the proposed legislation which provide financial aid through scholarships and loan programs.

However, section 109 of the bill, which refers to the exceptional financial need of scholarship program, should be extended to 2 years with the amount of funds increased proportionately.

We support the amended section 787, educational assistance to individuals from underrepresented minority groups and disadvantaged backgrounds. Because of the size of the unmet needs, we recommend that the budget authorization be increased to $40 million.

Fourth, in Section 103, we support the priority given for construction projects for schools expanding from a 2-year to a 4-year program and for new schools which anticipate a predominantly minority student enrollment. The sums authorized should be increased from the proposed $5 million to $10 million.

Fifth, we support the new authority in section 111, which provides assistance to 2-year schools of medicine to convert to degree-granting institutions, which enables them to meet one of the requirements for accreditation.

We appreciate this opportunity to share our views.

[The prepared statement of Dr. Bowie follows:]

STATEMENT

of

Walter C. Bowie, Dean

School of Veterinary Medicine
Tuskegee Institute
Tuskegee Institute, AL 36088

Submitted to the

Subcommittee on Health and Scientific Research

of the

Committee on Human Resources

United States Senate

Washington, D. C.
March 12, 1980

The Honorable Howard M. Metzenbaum and members of the committee. I am deeply appreciative of the opportunity to present to you my views regarding the legislative proposals for Health Professions Educational Assistance as they relate to those issues of vital concern to this nation. Congress, in its attempt to provide all Americans with equal access to high quality health care, has reaffirmed its commitment to assure equal opportunity for all Americans to enter a health career.

In concert with this commitment of the Congress, I wish to highlight the role which the Tuskegee Institute School of Veterinary Medicine has played as it has sought to address, almost single-handedly, the matter of underrepresentation of minorities in the health profession of veterinary medicine. In addition, I wish to place in perspective the need for the federal government to continue its cooperative relationship with this institution in order that our program efforts are sustained. It is in the vital interest of this nation that this be done because of the unique role played by the Tuskegee Institute School of Veterinary Medicine in maintaining a truly integrated educational environment.

This nation finds itself facing a dilemma; one of overcoming deficiencies in minority health professions manpower, while there are concerns about a possible oversupply of non-minority health professions. There is no oversupply of minority health professionals. Rather, there is a serious shortage that is especially apparent in the field of veterinary medicine.

The data shows that of the 36,000 veterinarians in this nation, only 400 or 1% are black. To reach parity, 4,320 black veterinarians are required--a deficit of 3,920. The current ratio of black veterinarians to the black population is 1:110,678 vs. 1:5,179 for the white veterinarians to the white population.

The School of Veterinary Medicine at Tuskegee Institute is one of the only 22 schools of veterinary medicine in the United States and the only one located on a predominantly black college campus. Its mission is not being duplicated anywhere. For example, the veterinary school at Tuskegee is responsible for the training of 90% of all black veterinarians in this nation, including 99% of those located in the South. According to current data on black student enrollment at the veterinary colleges, it is clear that Tuskegee continues to be the nation's principal training ground for minority veterinarians.

The Tuskegee Institute School of Veterinary Medicine, truly a national resource, claims title to being the most integrated school of veterinary medicine in the United States. From its inception, it has served as a regional training institution through the Southern Regional Education Board, and its graduates are universally distributed in 44 states, the District of Columbia, and 15 foreign countries. Congress recognized the importance of this great institution by awarding special construction funds to Tuskegee Institute's School of Veterinary Medicine under a 1977 amendment to the Health Professions Educational Assistance Act.

Although other sections of the pending health manpower legislation are important, we wish to address four vital components which we believe should be included in any new system of federal support for health manpower training--institutional support, financial distress, student assistance and the Health Careers Opportunity Program.

Institutional support has always been a special problem for Tuskegee since it is a private educational institution and does not receive major state support. The veterinary school at Tuskegee receives less than ten percent of its budget from that source. Therefore, for several years, it has had to turn to the federal government for assistance under the Financial Distress Grant mechanism, P. L. 94-484, 788-B, in order to meet its annual costs of operation. As has been pointed out recently by the National Advisory Council on Health Professions Education, this authorization, although helpful, does not address the very critical program requirements essential for full accreditation and financial stability.

The House, through its appropriate Subcommittee on Appropriations, Labor and Health, Education, and Welfare has also addressed the above concerns. It stated in its Report #95-1248 that "the Committee recognizes the historically important role that the Tuskegee Institute School of Veterinary Medicine of Alabama; Xavier University College of Pharmacy of Louisiana; and Meharry Medical College of Tennessee have played in the education of disadvantaged students and expects the Department of Health, Education, and Welfare to provide financial assistance from the funds appropriated to these schools which are experiencing operating deficits." It further directed the Secretary of the Department of Health, Education, and Welfare to summarize the current financial status of these institutions and propose methods for meeting the immediate financial crisis, and in addition, submit a long-term proposal to permit fiscal stability in all three institutions.

To further evaluate the financial distress of the three institutions named above, appropriate task force assignments were made by the Secretary. In this regard, a Peer Management Consultant Team and a HEW Task Force assessed each institution and submitted recommendations. After a careful review of management and operations of the Tuskegee program, it was the consensus of both committees that " . . . the Tuskegee Institute School of Veterinary Medicine's overall management operations are in keeping with sound principles. The leadership provided by the academic management team is excellent." However, using criteria established by the Council on Accreditation of the American Veterinary Medical Association, specific attention was given to the identification of programs, equipment, facilities and staff needs that were critical to continued accreditation. Further, special costs attributable to the implementation of the recommendations were given full consideration.

In the above named reports, two major concerns were addressed: (1) the adequacy of current programs, facilities, staff, and (2) financial needs essential for full accreditation status.

The following are excerpts from the HEW Task Force Report (1/15/79).

> . . . nature and balance of curriculum . . . consistent with accreditation standards.
>
> . . . faculty/student ratio more apparent . . . than real; faculty time spend in academic reinforcement activities . . . secretarial and related duties created an "illusionary" positive faculty/student relationship. To meet minimal accreditation standards, projected increases in faculty and staff must receive high priority.
>
> . . . physical plant adequate to accommodate current and projected student body sizes.
>
> . . . if accreditation is to be obtained, improvement of the library is first priority. Expenditures of $126,000 per year over five years . . . is needed to upgrade . . . to acceptable level of quality.
>
> . . . greatest need is the acquisition of scientific and medical equipment for basic science departments and clinical medicine and surgery. A conservative estimate of $300,000 over the next four years will be required to bring this school to an acceptable level in scientific, clinical and instrumental equipment.
>
> . . . to offset instructional costs and provide acceptable clinical training, a minimum of $50,000 to $100,000 per year will be required.

The Secretary was advised that failure of the veterinary medical program at Tuskegee Institute to obtain significant additional funding over the next five years would preclude the development of a program of sufficient quality to justify accreditation.

It is apparent from the above excerpted reports that the future viability of this program is in jeopardy and without the federal government's commitment to address the school's chronic financial situation, the likelihood of this program continuing is in doubt.

It is therefore heartening to note that both pending Health Manpower bills (S-2144 and the Health Professions Educational Assistance and Nurse Training Act of 1980) and S-2375 (the Health Professions Training and Distribution Act of 1980 (HPTD)) seek to provide, through a revised Financial Distress mechanism, the long-term (five years) assurance which Tuskegee, Xavier, and Meharry require in order to reach fiscal solvency. Tuskegee strongly supports these important sections of both bills. However, we believe that the HPTD Act of 1980 more adequately addresses the needs of these three minority institutions and provides solutions consistent with our ability to respond.

We would recommend, however, that Section 788 (b) (2) (A) in S-2375 be amended to include the following substitute language.

> "The Secretary may enter into cooperative agreements for not more than five years with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing or public health that are national priority institutions (as defined in subparagraph c) to meet incurred or prospective costs of operation essential to remove such institutions from serious and long-standing financial instability, and if such an INSTITUTION HAS PREVIOUSLY RECEIVED GRANT SUPPORT UNDER SECTION 788 b) (as it existed prior to October 1, 1980): SUCH AN INSTITUTION MUST AGREE TO SUBMIT TO THE SECRETARY A PLAN PROVIDING FOR THE INSTITUTION TO ACHIEVE FINANCIAL SOLVENCY WITHIN FIVE YEARS AND AGREE TO CARRY OUT SUCH A PLAN."

In order to assure that appropriate health manpower is available, a continued federal commitment is essential to all health professions educational institutions. This commitment is just as vital for the Tuskegee veterinary medical program as it is for the majority health professions schools. We support a new national priority incentive grant program designed to achieve national objectives. Limited but assured flexible educational funds need to be provided to promote innovative approaches to health education.

Funds, such as the above, will permit the educational function of the school (as opposed to the services and research roles) to remain a major institutional priority. In addition, an institutional support program maintains the important cooperative relationship with the federal government, directs training efforts to increase health manpower, and decreases the pressure of rising tuition cost. Such tuition increases push low- and middle-income students out of the market.

The third legislative component of enormous concern is that which deals with student assistance. We believe it important that any new health manpower legislation addresses sufficiently the financial requirements of both low- and middle-income students pursuing a health career. We, therefore, support Sections 104 through 110 of the HTPD Act of 1980 which provide financial aid through loan programs and scholarships. However, Section 109 of the bill, which refers to the exceptional financial need scholarship program should be extended to two years with the amount of funds increased proportionately.

The fourth legislative component which we wish to address concerns the Health Careers Opportunity Program (HCOP). In our opinion, it is imperative that any new federal legislation assures that programs such as HCOP be upgraded and expanded. This program has been especially helpful to Tuskegee as it seeks to attract more and more young people who are socioeconomically and educationally disadvantaged into the health professions. A larger and more ambitious HCOP effort will be required to support the unmet recruitment needs for health professionals in the 1980s. The amended Section 787, "Educational Assistance to Individuals from Underrepresented Minority Groups and Disadvantaged Backgrounds" of the HTPD Act of 1980 should be further expanded to a budget authorization level of $40 million.

We thank you for the opportunity to bring to the committee's attention our special program efforts and the related concerns which we have addressed as regards four legislative components--institutional support, financial distress, student assistance, and the Health Careers Opportunity Program.

Senator **Metzenbaum**. Thank you very much.

I call upon Mr. Raymond Gosselin, president of the Massachusetts College of Pharmacy & Allied Health Sciences.

Mr. **Gosselin**. My name is Raymond A. Gosselin. I am president of the Massachusetts College of Pharmacy & Allied Health Sciences, located in Boston and Springfield, Mass. My statement reflects my views and that of my college, not necessarily those of other colleges or associations.

The college is a private, independent, and freestanding college founded in 1823 and is the second oldest college of pharmacy in the United States.

Its charter was changed by an act of the Legislature of Massachusetts in 1979, allowing the college to grant degrees in the allied health sciences. To date, we have developed one new program, that of pharmacy technology, a 1-year certificate program for the purpose of educating and training pharmacy technicians, the first such program in America.

The college feels strongly that there is a place for the private, freestanding professional school. With rapidly rising costs and demographic trends indicating a lesser pool of eligible individuals for college-level education, the college is at a disadvantage.

Massachusetts has no school or college of pharmacy in the State system. There are no colleges of pharmacy in the States of Maine, New Hampshire, and Vermont. Our college has been the principal source of supply for pharmacists for this major area of New England.

Without recourse to a State legislature or university heirarchy for funding to accomplish goals, we can be seriously hampered in modifying our programs to correspond with the demands being made at the Federal level for revision of the health care delivery system and its educational components.

The college has qualified over the past several years for funding under the health professions capitation grant program. The college has qualified except for 1 year for capitation funding, received a construction grant and special projects grant for minority student recruiting and retention.

Last year, the college qualified for support under the financial distress program. Funds awarded were based upon special needs to meet the accreditation requirements of the American Council on Pharmaceutical Education.

The college operates a second campus in the western part of Massachusetts, which as yet has not been accredited. It is our goal that this program will be accredited within a reasonable time. The college is convinced that the second campus can serve a very valuable function for the New England region.

Many students in the region will deny themselves an education in pharmacy because the only options open to them are attending schools in the large metropolitan areas of the very large State universities, located elsewhere.

The college encourages the recruiting of young people from medium sized and smaller cities, towns and villages, and also promotes their return to this environment for practice.

This, we feel, helps solve the maldistribution problem. We are concerned that while funding has been available for covering incremental costs for accreditation in existing programs, the Federal program does not readily provide funding for the development of new offsite degree programs.

We submit that this could be quite crucial in the years ahead, as the demands for health care in the outlying areas continue to grow. We feel strongly that some provision should be made in health manpower legislation for the availability of funding for such purposes.

We think that the provisions in Senator Schweiker's bill, S. 2144, for competitive special projects grants is very laudable and creative. This has strong appeal for those of us in the private sector of education.

However, without some suitable level of predictable entitlement funding, we are severely handicapped in our ability to prepare the grant proposals. Our faculty and professional staff resources are of necessity committed to teaching and in executing existing programs.

We therefore are in favor of the entitlement provisions of S. 2375 and the special projects provisions of S. 2144.

We think the financial distress provisions of S. 2144 are very creative and those in S. 2375 somewhat restrictive for institutions of our kind.

In any event, it is our view that a bill that would provide modest but predictable entitlement grants and significant funding for competitive special projects grants would constitute the best insurance against the need for financial distress grants.

Thank you very much.

Senator SCHWEIKER. Thank you.

Last year, HEW submitted a report to Congress on the financial needs of health professions schools at Meharry, Tuskegee, and Xavier colleges. In the cover letter to the report, Secretary Califano stressed the need for increased State, local, and private support to these institutions.

Has any progress been made in this regard in the intervening time?

Dr. BOWIE. We, too, have been concerned about lack of progress that has been made with respect to getting additional support from our States. As you well know, the three schools that have primarily had the problem in terms of the needs for financial distress funding are private institutions. The position that the States have taken in each instance is that these are not in fact State-supported institutions. They are private colleges, and although they do receive some very limited State support, they are not primarily the responsibility of the State.

I think it is important for me to point out, though, Senator, that these schools are national priority institutions.

For example, the School of Veterinary Medicine at Tuskegee, only one of 23 schools of veterinary medicine, takes students from really some several States, including—well, in fact, 34 States are now represented in the school at Tuskegee. Our graduates are located in 44 States, the District of Columbia, and 15 foreign countries. We believe these schools, these private institutions that have had this problem are really national resource institutions.

Senator SCHWEIKER. At the request of Senator Metzenbaum, Dr. Bowie, I would like to ask one of his questions.

Minority students make up only 8 percent of all medical students, and a lower percentage in other health professions.

Why is there such a gap between representation of minorities in health professions and in the general population?

Dr. BOWIE. I would ask my colleague, Dr. Hines, to respond to that, Senator.

Dr. HINES. Thank you, Senator.

The differential in the number of minorities in health profession schools is basically a question of access, and access takes several forms.

One is financial, ability to maintain oneself while in an institution. Another is the question of competitiveness in reaching desired goals of eligibility for admissions. Minority health profession schools, which we represent in this consortium have a special mission in terms of being sympathetic and empathetic to students coming from disadvantaged educational as well as economic background. We make special efforts to see to it that students are both admitted and graduate, and as a result, our institutions do have a special role to play in providing a national resource for minorities.

Other institutional commitments cannot of necessity be as great to minorities as are minority institutions and therefore the need for supporting and maintaining the quality of education at these institutions is significant. The discrepancy, we believe, is one in which a good deal of Federal assistance is needed in order to bridge that gap. The bills that are being discussed here, we think, will have some supportive qualities to improving that situation.

Senator SCHWEIKER. Thank you.

[Statements submitted for the record follow:]

TESTIMONY FOR SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE, WASHINGTON, D.C. MARCH 12

Mr, Chairman:

My name is Ralph H. Hines, I am the Provost and Executive Vice President of Meharry Medical College, located in Nashville, Tennessee. It is a pleasure and privilege to present this testimony to you today. I am here to inform you about Meharry and its special concerns and needs, and to give our support to Senate Bill S-2375, the Health Profession Training and Distribution Act of 1980.

Meharry Medical College, founded in 1876, is the Nation's only privately endowed, predominently black institution of medicine and dentistry. The College has graduated 43 percent of this nation's practicing black physicians and dentists. It consists of schools of medicine, dentistry, graduate studies, and the allied health disciplines. During this decade the College has realized a dramatic enrollment increase, in keeping with the national concern about alleviating health manpower shortages, shortages which have been particularly serious in minority communities. Today Meharry has a total enrollment of 1,100 students in all programs, compared to 434 ten years ago. Slightly over half of this total is in medicine and dentistry, with over 500 preparing for the M.D. degree. Some 77 percent are black, 23 percent are non-black, consisting of white, hispanic, native american, foreign and asian american students.

Meharry, throughout its history, has served as a special national and regional resource for expanding access to health sciences training and service. There are several ways in which Meharry has led the nation, ways which add further impact and significance to the essential role it plays. For example, the College leads the nation in the percentage - (76 percent) of its graduates who are working among the urban and rural poor, groups which have the highest rates of illness in our nation. Also, of all black sutdents in the twenty-nine medical schools in the South, 37 percent are enrolled in study at Meharry.

Some 40 percent of the College's medical graduates return to the South to settle and practice, twice the number of all other minority medical graduates and nearly twice the number of all other graduate physicians. Meharry graduates are known for their commitment to primary care and more of them go into primary care settings than do the graduates from any other medical school (76 percent). Finally, for the nation as a whole, 15 percent of all medical students come from "disadvantaged" backgrounds, from families where total income is below $10,000 annually; at Meharry that figure is 49 percent, the highest in the country.

For the past five years we have seen an erosion in the number of black and other minority students who have gained access to the health sciences field. In fact there are fewer black students in the entering classes of medicine and dentistry today than there was in 1972. (Medicine 1971-72 - 7.1%; 1978 - 6.4% -- Dentistry 1971-72 - 5.2%; 1978-79 - 4.4%). The following table illustrate the dramatic changes which have occured during this period and points out the importance of a national commitment to assisting minority health sciences institutions.

TABLE 1

BLACK ENROLLMENT IN FIRST-YEAR CLASSES IN U.S. MEDICAL SCHOOLS (1971-1978)

YEAR	NUMBER AND PERCENT OF ENROLLMENT		TOTAL FIRST YEAR ENROLLMENT
1971-72	882	7.1	12,361
1972-73	957	7.0	13,677
1973-74	1,027	7.3	14,154
1974-75	1,106	7.5	14,763
1975-76	1,036	6.8	15,295
1976-77	1,040	6.7	15,613
1977-78	1,085	6.7	16,136
1978-79	1,061	6.4	16,501

Source: Medical School admission requirements 1980-81, United States and Canada, 30th edition, Association of American Medical College, One Dupont Circle, Washington, D. C. 20036.

TABLE II
MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL
ACADEMIC YEAR 1971-72 THROUGH 1978-79 1/

Academic year	Total first year students	Racial / ethnic category							Percent minority of total first-year students
		Black	American Indian	Mexican-American	Puerto Rican	Oriental (Asians)	Other minority	minority	
1971-72	4,705	245(5.2%)	4	27	13	112(2.4%)	11	412	8.8
1972-73	5,287	266(5.0%)	5	53	3	138(2.6%)	10	475	9.0
1973-74	5,389	273(5.3%)	12	64	5	141(2.6%)	34	529	9.8
1974-75	5,555	279(5.2%)	12	68	7	142(2.6%)	43	551	9.9
1975-76	5,697	298(5.2%)	22	64	11	186(3.2%)	56	637	11.2
1976-77	5,869	291(5.0%)	21	81	15	174(3.0%)	68	650	11.1
1977-78	5,890	296(5.0%)	10	2/	2/	225(3.8%)	2/	641	10.9
1978-79	6,301	280(4.4%)	16	122*		263(4.2%)		681	10.8

SOURCE: AMERICAN DENTAL ASSOCIATON, COUNCIL ON DENTAL EDUCATION. MINORITY STUDENT ENROLLMENT AND OPPORTUNIITES IN. U.S. DENTAL SCHOOLS, FOR 1971-72 AND FOR 1972-73. MINORITY REPORT: SUPPLEMENT OF ANNUAL REPORT ON DENTAL EDUCATION 1973-74, AND REPORTS FOR SUBSEQUENT ACADEMIC YEARS. CENSUS OF POPULATION PART I, U.S. SUMMARY 1970. BUREAU OF THE CENSUS POPULATON PROFILE OF THE UNITED STATES: 1978.

This record of national leadership is related to several critical problems which place Meharry in a special situation among the nation's private medical institutions. Many obstacles confront us in achieving adequate financing to maintain and improve our teaching and instructional strength. We believe that S-2375 addresses many of these needs in a forthright and responsive manner.

One of these problems is the result of the College's unique national mission. Meharry's Traditional purpose expresses itself as an "empathy for the disadvantaged of all origins." In keeping with this historic and unique mission the College enrolls more disadvantaged students, as mentioned above, than any other medical school in the United States. Some 86 percent of our student body requests and need financial aid to help them pay tuition and other expenses. Tuition costs stand currently at $5,000 per annum, up 60 percent from two years ago. While the College relies heavily on tuition and fees for income, raising the tuition much beyond the present level would result in only a marginal increment in operating income, and would be counter-productive to the College's special role in educating the disadvantaged. Even for those few who can pay, the gap between tuition and fees and what their education costs per year is sizeable. Thus Meharry's scholarship needs are substantial, and meeting them places significant financial burdens on the College.

Another factor which contributes to a weakened financial situtión is related to the special educational needs of our students. Many bring with them the remnants of prior educational disadvantage. Academic enrichment activities are therefore, a regular part of the College's program. These efforts require core staff as well as qualified support personnel. This means that already scarce resources have more demands made upon them than should be allowed or acceptable. As a result, for example, the number of our full-time basis sciences faculty has increased only marginally during a period when total medical school enrollment has nearly doubled.

The College's background suggests another factor which impacts upon its finances. Meharry was the creation of the Freedman's AID Society during the reconstruction era. Its early years were characterized by both struggle and minimal resource. It survived and the Flexner Report Praised Meharry as an institution "worth preserving". Since then it has resolutely carved out for itself a unique place in the network of health sciences institutions in this country. However, the years of doing "somewhat more" with "somewhat less" have meant the College's endowment base is insignificant and thus has been unable to keep pace with growth and demands in other areas. In addition, there is no direct state support which we can count on. Tennessee is prohibited by state constitutional law from providing direct financial assistance to a private or parochial institution.

A final item which as contributed to the financial situation of the College is one common to many educational institutions. I refer to the escalating costs of operations. Over the past several years fuel and energy costs have increased drastically, as have building upkeep and insurance premiums, service expenses, salary and employee benefits, and material and supply expenses. At Meharry every effort is being made to reduce expenses and to cut back non-essential activites. Management techniques have been introduced to implement cost reductions wherever possible. However, increased costs remain a pressure point, and in combination with other factors, have added to the College's weakened financial situation.

Meharry has been in financial distress for many years. It has been one of several institutions for which Congress sought to provide special assistance under Section 773 of the Public Health Service Act, the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157). Under Section 773, grants were authorized to assist any school of medicine, dentistry, osteopathy, optometry, verterinary medicine, pharmacy or podiatry which could prove serious financial straits. Meharry has qualified for and received grant awards under this financial distress mechanism since its inception. This assistance has been invaluable.

However, while the financial distress program has provided Meharry certain relief in meeting its needs, a number of less than beneficial side effects have also resulted, effects which undermine and curtail our future financial stability. Many of the hoped for goals envisioned for the program under Section 773 have not been realized satisfactorily. Some of its side effects have contributed to worsening the situation, in fact, and the posture of Meharry today is such that our very survival is at issue.

I am respectfully requesting, therefore, that this Committee and other appropriate Legislative Committees of the Congress carefully consider the improvements made in S-2375 which is more responsive to the needs of Meharry Medical College and other predominently black health sciences institutions and adopt the provisions contain therein which would ensure the financial stability of these institutions.

We strongly urge the adoption of this Bill because it does give emphasis to areas of grave concern to us and proposes solutions to assist the real and vital areas of health manpower shortages and problems.

Its attention to scholarships and loan needs of disadvantaged students; its thrusts in increasing and redistributing family medicine professionals; and its timely support to institutions meeting national priorities are all valid and justifiable strengths which are in the national interest.

This new approach would represent an enormous improvement over the means presently available to assist Meharry and other predominently black health professional schools and would effectively eradicate most of the serious problems outlined above. It would help create the guarantees we need in overcoming many obstacles, assure our survival, and secure the financing required to maintain the College's unique educational strength in pursuit of its indispensable national mission.

I am grateful for this opportunity to speak in support of this improved approach to meeting our special needs, and urge your early and favorable consideration.

THANK YOUR.

Testimony on the Health Professions Training and Distribution Act of 1980 (S.2375) and on the Health Professions Educational Assistance and Nursing Training Act of 1980 (S.2144).

Submitted to the Subcommittee on Health and Scientific Research
of the
Committee on Human Resources
United States Senate
by
The Consortium of Minority Health Professions Schools

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March 12, 1980 Washington, D.C.

Mr. Chairman and distinguished members of the Subcommittee:

The Consortium of Minority Health Professions Schools is appreciative of the opportunity to share with you our views regarding the nation's health manpower needs.

The Consortium of Minority Health Professions Schools includes the Charles R. Drew Postgraduate School of Medicine (Los Angeles), the Meharry Medical College (Nashville), the School of Medicine at Morehouse College (Atlanta), the College of Pharmacy at Florida A & M University (Tallahasee), the College of Pharmacy at Texas Southern University (Houston), the College of Pharmacy at Xavier University (New Orleans), and the School of Veterinary Medicine at Tuskegee Institute (Alabama). These institutions are national priority institutions which provide a service in the national interest by educating and developing capable minority health manpower.

With the passage of the Health Professions Educational Assistance Act of 1963, Congress declared that the availability of high quality health care to all Americans is a national goal. Congress has further declared that health professions personnel are a national resource and that it is therefore appropriate to provide support for the education and training of such personnel. Now that we have entered the 1980s we must seek to reach these goals through a continuation of the partnership between the federal government and the health professions schools in order to correct problems of geographic distribution, under-representation of minorities and women, and the need for health professionals trained for primary care.

In concert with the commitment of the Congress that the health care system provide all Americans equal access to health care, the members of the Consortium of Minority Health Professions Schools wish to highlight the contributions of our institutions in the training of minority health professionals. Equally important are the significant numbers of our graduates who provide health services to communities with large numbers of persons who are socially and economically disadvantaged. However, much remains to be done. Although blacks comprise almost 12 per-cent of the U.S. population, blacks represent only 1.7 per cent of the physicians, 1.8 per cent of the dentists, 2.0 per cent of the pharmacists and 0.7 per cent of the veterinarians in this country. The critical need for more black health professionals is apparent.

Of 126 medical schools in the United States, only three (3) are at predominantly black institutions; only one (1) of some twenty-two (22) schools of veterinary medicine is predominantly black; and among some seventy-two (72) schools of pharmacy in the U.S., only fpur (4) are at predominantly black institutions.

It is important to note that from these few health professions schools, over 50 per cent of the black pharmacists in the U.S. have graduated, 90 per cent of all black veterinarians in the U.S. are graduates of the Tuskegee Institute School of Veterinary Medicine and 43 per cent of all black physicians and dentists in the United States are graduates of Meharry Medical College (and 76 per cent of the graduates of Meharry Medical College are engaged in primary care.)

It is critical therefore that the capacity of our institutions to educate and train physicians, dentists, pharmacists, veterinarians be strengthened through new legislation.

The training of minority health professionals at our institutions can be maintained if the new health manpower legislation contained, at a minimum, authorities for: institutional support, financial distress grants, scholarships and loans for disadvantaged students, the health careers opportunity program, grants for needed facilities and conversion funds. These authorities, if enacted and implemented, would enhance the capability of these national priority institutions to meet the nation's minority health manpower needs, and the need for primary care physicians in underserved rural and urban communities.

Mr. Chairman and distinguished members of the Subcommittee, in order that our institutions maintain and enhance their capabilities to develop needed minority health professionals, we need:

A. Institutional support as an investment to enable our institutions to maintain high standards and to return that investment to the nation in the form of uniquely qualified health professionals to meet the health care needs of rural and urban communities.

Through a joint venture with the federal government we seek this investment to help us reverse the decline in the percentage of black and other minority students enrolled in health sciences programs. It is our position that this joint venture with the federal government would signal a renewed national commitment to solving the problems of decreasing minority representation and the goal of parity for minorities in the health professions.

We present to you the data. The data portrays a dilemma for the nation: to overcome deficiences in minority health professions manpower, while there are concerns about a possible oversupply of non-minority health professionals. There is no oversupply in minority health professionals. Rather, there is a serious deficiencey of minority health professionals, which represents a national crisis.

The facts are contained in the following tables.

Table I

BLACK ENROLLMENT IN FIRST-YEAR CLASSES IN U.S. MEDICAL SCHOOLS (1971-1978)

YEAR	NUMBER AND PERCENT OF ENROLLMENT		TOTAL FIRST YEAR ENROLLMENT
1971-72	882	7.1	12,361
1972-73	957	7.0	13,677
1973-74	1,027	7.3	14,154
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1976-77	1,040	6.7	15,613
1977-78	1,085	6.7	16,136
1978-79	1,061	6.4	16,501

SOURCE: DATA FROM PUBLICATIONS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036

TABLE II

MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL

ACADEMIC YEARS 1971-72 THROUGH 1978-79 1/

Academic year	Total first year students	Racial/ethnic category Black	American Indian	Mexican-American	Puerto Rican	Oriental (Asians)	Other Minority	Total Minority	Percentage minority of total first-year Students
1971-72	4,705	245(5.2%)	4	27	13	112(2.4%)	11	412	8.8
1972-73	5,287	266(5.0%)	5	51	3	136(2.6%)	10	475	9.0
1973-74	5,389	273(5.3%)	12	64	5	141(2.6%)	34	529	9.8
1974-75	5,555	279(5.2%)	12	68	7	142(2.5%)	43	551	9.9
1975-76	5,697	298(5.2%)	22	64	11	186(3.2%)	56	637	11.2
1976-77	5,869	291(5.0%)	21	81	15	174(3.0%)	68	650	11.1
1977-78	5,890	296(5.0%)	10	2/	2/	225(3.8%)	2/	641	10.9
1978-79	6,301	280(4.4%)	15	122*		263(4.2%)		681	10.8

1/ Excludes University of Puerto Rico.

2/ The data for 1977-78 differ from earlier years because of changes in racial/ethnic categories used for data collection. In 1977-78 there were 110 first-year students under a new category "Hispanic". Also, the former category for "Other minority" was eliminated.

* Hispanic including Puerto Ricans in U. S. Schools.

NB Blacks = 11.6% of total U.S. population. Hispanics - 5.6% and Asians (all types) = 0.9%

SOURCE: AMERICAN DENTAL ASSOCIATION, COUNCIL ON DENTAL EDUCATION. MINORITY STUDENT ENROLLMENT AND OPPORTUNITIES IN U.S. DENTAL SCHOOLS, FOR 1971-72 AND FOR 1972-73. MINORITY REPORT: SUPPLEMENT OF ANNUAL REPORT ON DENTAL EDUCATION 1973-74, AND REPORTS FOR SUBSEQUENT ACADEMIC YEARS. CENSUS OF POPULATION PART I, U.S. SUMMARY 1970. BUREAU OF THE CENSUS POPULATION PROFILE OF THE UNITED STATES: 1978.

TABLE III

Minority Undergraduate Enrollment in Schools and Colleges of Pharmacy

Academic Years 1971-1972 through 1978-1979

				Racial/Ethnic Category										
Academic Year	Total Enroll-ment	White Americans	%	Blacks	%	*	Hispanics	%	Native Americans	%	Asian Ancestary	%	Foreign	%
1971-1972	16,476	14,831	90.0	618	3.7	--	203	1.2	8	.04	816	4.9	--	--
1972-1973	18,445	16,295	88.3	659	3.6	372	254	1.37	29	0.1	720	3.9	488	2.6
1973-1974	20,830	18,358	88.1	619	3.0	314	343	1.7	25	0.1	697	3.3	780	3.7
1974-1975	22,688	19,899	87.7	727	3.2	377	278	1.2	32	0.1	690	3.0	1,062	4.6
1975-1976	23,836	20,741	87.0	915	3.8	470	359	1.5	36	0.2	799	3.2	1,006	4.3
1976-1977	23,465	20,552	87.5	938	4.0	481	353	1.5	37	0.2	761	3.2	824	3.5
1977-1978	23,273	20,271	87.1	984	4.2	533	360	1.5	39	0.2	809	3.4	810	3.5
1978-1979	23,078	20.108	87.1	942	4.1	457	376	1.6	34	0.1	911	3.4	707	3.1

Source: American Journal of Pharmacy Education 1979

*Total number enrolled in the traditionally black colleges and Schools of Pharmacy

TABLE IV

NATIONAL MINORITY HEALTH PROFESSIONALS

HEALTH PROFESSIONAL	TOTAL	BLACK%	PARITY	NEEDED/%	BLACK/BLACK POPULATION	WHITE/WHITE POPULATION
Physicians	348,443	6,106/1.7	41,813	35,707/10.3	1:6,001	1:540
Dentists	112,000	2,098/1.8	13,440	11,342/10.2	1:13,294	1:1,684
Optometrists	24,242	186/0.7	2,909	2,723/11.3	1:49,951	1:7,695
Pharmacists	122,500	2,501/2.0	14,700	12,199/10.0	1:11,151	1:1,542
Podiatrists	8,000	250/3.1	960	710/8.9	1:111,564	1:23,889
Osteopaths	15,000	250/1.6	1,800	1,550/10.4	1:111,564	1:12,551
Veterinarians	36,000	252/0.7	4,320	4,068/11.3	1:110,678	1:5,179

Prepared by: NC Health Manpower Development Program
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DATA FROM: MINORITIES AND WOMEN IN THE HEALTH FIELDS, SEPTEMBER, 1975; HEALTH MANPOWER REFERENCES: AND HEALTH RESOURCES AND UTILIZATION STATISTICS 1976; NATIONAL CENTER FOR HEALTH STATISTICS: A REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL IN THE U. S., 1978.

Black Americans should not have their legitimate and serious needs for more health professionals submerged in the data concerning the overall health manpower projections of the Department of Health Education and Welfare. In every health profession, blacks are critically underrepresented as shown in Table IV.

These minority health manpower shortages have resulted in an array of serious health problems in the black communities of the nation--a shortened life expectancy for blacks, some 6-8 years less than for whites; higher infant mortality rates; a two-fold greater incidence of high blood pressure; and many other alarming statistics.

The foregoing data illustrate the critical need to significantly increase the number of blacks and other underrepresented minorities in the health professions.

The institutions of the Consortium are working diligently to supply the needed health manpower for our nation.

Tuskegee Institute, one of twenty-two (22) schools of veterinary medicine in the United States, has trained ninety percent (90%) of all minorities in veterinary medicine and ninety-nine percent (99%) of all black veterinarians in the South. Its graduates are distributed in forty-four (44) states, the District of Columbia and fifteen (15) foreign countries.

There are seventy-two (72) accredited colleges of pharmacy in the United States. For the past five years they have produced an average of 225 black pharmacists each year. Over fifty percent of those graduates were produced by the four (4) traditionally black colleges of pharmacy, including Florida A & M University, Texas Southern University and Xavier University (Louisiana).

Forty-three percent (43) of all black physicians and dentists practicing in the United States are graduates of Meharry Medical College.

Thirty-seven percent (37%) of all black students in the twenty-nine (29) medical schools located in the south are enrolled at Meharry.

The new School of Medicine at Morehouse College projects an enrollment of fifty-six (56) students in 1980-81 with forty-eight (48) graduates by 1985, increasing in both total enrollment and in the number of graduates thereafter.

Forty-nine percent (49%) of all black dental students in the South are at Meharry.

It is also noteworthy that seventy-six percent (76%) of Meharry graduates are engaged in primary care.

Charles R. Drew Postgraduate Medical School is providing postgraduate training in family practice and the other medical specialties for minority health professionals and is delivering health care to an underserved inner city population.

B. Financial Distress Grants are needed to reduce the operating deficits which are the result of past marginal financial support of high cost health sciences education programs. Section 773 of the Public Health Service Act, the Comprehensive Health Training Act of 1976, authorizes support for schools of medicine, dentistry, osteopathy, veterinary medicine, pharmacy and podiatry which are in need of financial assistance. It was envisioned that some schools would require funding in order to meet certain conditions of accreditation and enrollment increases and that these conditions were related to time-limited financial burdens.

It was further envisioned that the amount of money required by each institution receiving financial distress assistance would be a small fraction of their total budget. A factor somewhere between one and five percent was believed to be appropriate federal assistance.

These few institutions have carried the burden of preparing black health professionals, but it is a difficult and costly task. In addition to the fiscal constraints which all institutions have, minority institutions, with missions to serve the disadvantaged, have a large percentage of students from low income families; ninety percent (90%) of them need significant financial assistance.

A continued federal commitment to the minority health professions institutions is needed in order to assure that the right kinds of health professions are available in the future.

The Congress has recognized our need for financial assistance. The House through its Subcommittee on Appropriations, Labor and Health, Education and Welfare has written in its Report #95-1248 that:

> "The Committee recognizes the historically important role that the Tuskegee Institute School of Veterinary Medicine of Alabama, Xavier University College of Pharmacy of Louisiana, and Meharry Medical College of Tennessee have played in the education of disadvantaged students and expects the Department of Health, Education and Welfare to provide financial assistance from the funds appropriated to these schools which are experiencing operating deficits."
>
> "It further directs the Secretary of the Department of Health, Education and Welfare to summarize the current financial status of these institutions and propose methods for meeting the immediate financial crisis as well as providing a long-term proposal to achieve fiscal stability."

We would now like to comment on specific provisions of the bills under consideration by this Committee.

Both the "Health Professions Training and Distribution Act of 1980 (S.2375)" and the "Health Professions Educational Assistance and Nurse Training Act of 1980 (S.2144)", introduced by Senator Schweiker, are concerned about the need to provide assistance to schools who suffer acute and chronic financial distress.

The Consortium of Minority Health Professions Schools strongly supports these important sections of both bills. However, S.2375 more adequately addresses the needs of minority institutions and provides solutions consistent with our ability to respond.

We would recommend that Section 788(b)(2)(A) in (S.2375) be amended to include the following substitute language.

> "The Secretary may enter into cooperative agreements for up to five years with schools of medicine, osteopathy, dentistry, veterinary medicine, optemetry, pharmacy, podiatry, nursing or public health that are national priority institutions (as defined in subparagraph (C) to provide financial assistance to such institutions to meet incurred or prospective costs of operation essential to remove such institutions from serious and long standing financial instability, if such an institution has previously received grant support under

Section 788 (as it existed prior to October 1, 1980); and if such an institution agrees to submit to the Secretary a plan providing for the institution to achieve financial solvency within five years".

We strongly support these portions of Senate Bill 2375 which would insure the continued functioning of our institutions. Without this kind of assistance, minority institutions are faced with the likelihood of having to close their doors, in spite of declining access of minorities to careers in the health professions and rising expectations of minority citizens.

C. Student Assistance. Mr. Chairman, as a national consortium, we are witnessing with great concern and stress the increasing number of low and middle income students who cannot afford a health sciences education. We have historically sought out and encouraged young people to develop their talents and to acquire needed skills. These skills are being used to improve the quality of life for all Americans. Yet, the economics of the 1980s could force our institutions to seek only those students who could afford to pay from their own resources for graduate and professional education. Therefore, we support a student financial assistance program that would maintain the democratic concept of choice.

A student financial need profile was presented by member institutions of the Consortium to the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, Houston, Texas, October 5, 1979. The student financial need profile reflects the following:

> Meharry Medical College - "In keeping with this historic and unique mission the college enrolls more disadvantaged students.. than any other medical school in the United States. Some 86 percent of our student body requests and receives financial aid to help them pay tuition and other expenses."
>
> School of Medicine at Morehouse College - "Seventeen of the students in the Charter Class (24 students) are recipients of National Health Service Corp Scholarships, one is the recipient of an Exceptional Need Scholarship, another is the recipient of an Armed Forces Health Professions Scholarship. Three of the remaining students have received scholarships and loans from various private sources, including medical school funds."

Xavier University of Louisiana School of Pharmacy - "Our current tuition rate of $2,400 per year is well below the national average of $3,100 for private schools of pharmacy, but the economic status of our students is proportunately far lower than that of their peers in other institutions.

Given the financial need profiles of students enrolled in the institutions of our Consortium, an effective student assistance program is needed.

There is considerable merit to state scholarship programs as put forth by Senate Bill 2144. However, the Consortium of Minority Health Professions Schools believes that the following sections on student assistance in S. 2375 more effectively meet the need:

Section 104 - Federally - Insured Student Loans

Section 105 - Health Professions Student Loans

Section 106 - Service Contingent Loan Program

Section 107 - Traineeships to Students in Schools of Public Health and Health Administration

Section 108 - National Health Service Corps

Section 108 of this bill (the Exceptional Financial Need Scholarship Program) should include the first two years of education with the amount of support increased proportionately.

D. The Health Careers Opportunity Program. New Health Manpower legislation must insure that the Health Careers Opportunity Program (HCOP) is upgraded and expanded. HCOP is the vehicle through which federal grants and contracts are made to health professions schools to assist young people who are socially, economically, and educationally disadvantaged enter the health professions.

An expanded HCOP will be required for the unmet needs for minority health professionals in the 1980s. Although Section 787 "Educational Assistance to Individuals from Underrepresented Minority Groups and Disadvantaged Backgrounds" of the HPTD Act of 1980 includes many points of vital concern, the existing authorities directed toward this end should be consolidated and the authorization increased to 40 million annually.

As representatives of a national consortium of diverse institutions offering a variety of health professions programs, we are of one voice that new health manpower legislation must insure that the Health Careers Opportunity Program (HCOP) is improved and adequately funded.

Access to many health sciences careers has been limited for a variety of reasons. Perhaps two of the most recognizable are: (1) inadequate academic preparation for admission to professional schools, and (2) lack of adequate financial support.[1]

These two overriding and mitigating negative factors are added barriers to increasing the needed pool of qualified health professionals from the ranks of the economically and educational disadvantaged.

Programs that help black high school students receive adequate academic preparation, together with support programs in college will help to insure greater participation of blacks and other minorities in the health professions.

E. Facilities. To meet the required standards of accrediting bodies, it is imperative that we have adequate educational facilities for our students. Previous legislation, Public Law 94-484, has supported the construction of such facilities for all medical schools. The proposal in S. 2144 and in S. 2375 for construction of educational facilities would be of benefit to the new and developing School of Medicine at Morehouse College, which opened in September, 1978. The School of Medicine at Morehouse College is currently operating in loaned facilities of the College, which are not adequate for the needs of the School of Medicine. Morehouse is dedicated to significantly improving health care delivery to underserved rural and urban populations by producing medical care practitioners with a commitment to primary care.

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[1] D.A. Evans, et. al, Traditional Criteria as Predictions of Minority Student Success in Medical School, J. Med. Educ. 50: 934-939.

The Consortium of Minority Health Professions Schools supports Section 775 of S. 2144 and Section 103 of S. 2375.

Although we support Section 775 in S. 2144 and Section 103 of S. 2375 we urge that the authorized sums for these sections be increased to ten million dollars, in order that sufficient sums will be available for the construction of needed facilities.

Mr. Chairman, on the 13th day of May 1976, the Subcommittee Report to the Committee on Labor and Public Welfare provided special recognition to a member of our Consortium. It was reported that,

> "The Committee (on Labor and Public Welfare) intends...to initiate new health professions schools to be redirected to assist in the alleviation of the specialty and geographic maldistribution of health professions. It is not enough simply to train more health professionals. The additional professions must be in appropriate specialities and practice in areas where they are needed. The Committee expects that assistance will be to new schools which actively seek to train professionals for practice in the primary care medical specialities and in areas which are less well served. The Committee believes that schools which are organized in new ways and whose curricula vary from the traditional pattern are more likely to produce the new practitioners needed by the nation. The program now being developed at Morehouse College is an example of the sort of program which will be supported by the revised startup authority."

F. Conversion Support. The School of Medicine at Morehouse College has accepted the challenge of training health professionals who will go into primary care and serve in underserved areas. To increase its effectiveness in meeting this challenge, the school has planned during 1983 to develop from a two-year to a four-year M.D. degree granting institution. Conversion to a four-year institution is a requirement of the Liaison Committee on Medical Education (LCME) for accreditation.

To meet this accreditation requirement, it will be necessary that this new and developing medical school receive support for conversion to a degree-granting institution. Therefore, although Section 713 of S. 2144 is helpful in this regard, the Consortium finds that Section 792 (a)(1) of S. 2375 is more helpful.

"The Secretary may make a single grant to any private two-year school of medicine... to assist such schools in converting to a school accredited to grant the degree of doctor of medicine. The amount of such grant shall be wqual to the product of $50,000 and the number of third year students that will be initially enrolled in such school."

Conversion support from the Federal Government has been established in previous health manpower bills. For example, the current law Public Law 94-484, supported the conversion of the University of Nevada School of Medical Sciences from a two year to a four year M.D. granting program.

In summary, we urge the following:

1. The enactment of sections 771 and 772--"National Priority Incentive Grants" of Senate Bill 2375.
2. That section 788(b)(2)(A) "Financial Distress Grants" of Senate Bill 2375 be enacted with the substitute language as recommended on pages 9 and 10 of this testimony.
3. The enactment of the student assistance provision contained in section 104--"Federally-Insured Student Loans"; in section 105--"Health Professions Student Loans"; in section 106--"Service Contingent Loan Program"; in section 107--"Traineeships to Students in Schools of Public Health and Health Administration"; in section 108--"National Health Service Corps" and a modification of section 108--"Exceptional Financial Need" Scholarships Programs (extended to two years with a proprotionate increase in funds).
4. The enactment of section 787(a)--"Educational Assistance to Individuals from Underrepresented Minority Groups and Disadvantaged Backgrounds" of Senate Bill 2375.
5. That section 103--"Construction" Grant Authority of Senate Bill 2375 be enacted with an increase in the appropriation to ten million dollars.
6. The enactment of section 792(a)(1)--"Conversion Projects" of Senate Bill 2375.

We thank you for the opportunity to present to this Committee vital issues concerning the health manpower needs of the nation. These legislative measures proposed and/or supported by the Consortium of Minority Health Professions Schools, if enacted, will enable our institutions to continue their service to the nation, in meeting national priority needs.

Respectfully submitted:

Louis W. Sullivan, M.D., Dean and Director
School of Medicine at Morehouse College

Ralph H. Hines, Ph.D., Executive Vice President
Meharry Medical College

Walter C. Bowie, D.V.M., Ph.D., Dean
School of Veterinary Medicine, Tuskegee Institute

M. Alfred Haynes, M.D., M.P.H, Dean
Charles R. Drew Postgraduate Medical School

Charles A. Walker, Ph.D., Dean
School of Pharmacy, Florida A & M University

Anthony Rachal, M.Ed., Executive Vice President
College of Pharmacy, Xavier University of Lousiana

Patrick Wells, Ph.D., Dean
College of Pharmacy, Texas Southern University

Testimony on the Health Professions Training and Distribution Act of 1980 (S.2375) and on the Health Professions Educational Assistance and Nursing Training Act of 1980 (S.2144).

Submitted to the Subcommittee on Health and Scientific Research
of the
Committee on Human Resources

United States Senate

by

Louis W. Sullivan, M.D., Dean and Director
School of Medicine at Morehouse College
Atlanta, Georgia

March 12, 1980 Washington, D.C.

Mr. Chairman and distinguished members of the Subcommittee:

I am grateful for the opportunity to share with you my views concerning the renewal of Health Manpower Legislation.

The primary focus of my comments will be on ways in which the Federal Government can assist a new two year school of basic medical sciences, such as the School of Medicine at Morehouse College in its efforts to train more primary care physicians for work in underserved rural areas and the inner cities.

First, I wish to share with you some information about the School of Medicine at Morehouse College.

A. Morehouse College

Morehouse College is a liberal arts institution, in Atlanta, Georgia. For more than 113 years this institution has provided quality education to a predominantly black student body, and has enabled its graduates to pursue successful careers and leadership roles in American society. It has a long list of distinguished alumni: Martin Luther King, Jr. (Nobel Peace Prize Winner); Martin Luther King, Sr.; The Honorable Maynard Jackson (Mayor, City of Atlanta); The Honorable Julian Bond (Georgia State Senator); Lerone Bennett (Senior Editor, Ebony Magazine); and many more.

Morehouse College has provided the undergraduate education for more college presidents, more Ph.D.'s, more physicians, more dentists, more lawyers, more MBA's, more bank presidents--than any other predominantly black college in the United States of comparable size. The reason is the College's heritage of academic quality. Morehouse is one of only four Georgia educational institutions with a chapter of Phi Beta Kappa. Morehouse's contribution to the science and health manpower pool in this country has been, and continues to be, outstanding. Of the College's 4,500 alumni, 8% are physicians, dentists, or holders of a Ph.D. in a science discipline. Of some 6,600 black physicians in the United States, more than 6% are graduates of Morehouse College.

B. The School of Medicine

Because of the College's commitment to better serve the health care needs of the nation's poor and minority citizens, the College received, in February, 1973 and in July, 1974, federal assistance for the design and development of a two year program in basic medical sciences education that would be responsive to the needs of under-represented minorities and low income students.

The School of Medicine at Morehouse opened in September, 1978 as a two year school of basic medical sciences with a charter class of 24 students. The School of Medicine at Morehouse College is the first medical school to be founded by a minority institution in the twentieth century.

The School of Medicine at Morehouse College has a primary mission to educate and train students from disadvantaged backgrounds for medical careers as primary care physicians (family practitioners, general internists, general pediatricians, etc.), to work in medically-underserved rural and inner-city communities, with poor and disadvantaged populations.

Because of the School's commitment to develop a medical-education program to better serve the health care needs of the nation's poor and minority citizens, the School has received endorsements of support from the Honorable Jimmy Carter; for Secretary of the Department of Health, Education and Welfare , the Honorable Joseph Califano; the National Medical Association; the American Medical Association; the Medical Association of Georgia; the Georgia State Medical Association; the Association of American Medical Colleges; the Honorable George Busbee, Governor of the State of Georgia; the Georgia Legislature; the Mayor of Atlanta; the Fulton County Commission; the Atlanta Chamber of Commerce; and the Carnegie Council.

The efforts by the School of Medicine at Morehouse College were cited in the Health Professions Educational Assistance Act of 1976:

> "The Committee intends for the program to initiate new health professions schools to be redirected to assist in the alleviation of the specialty and geographic maldistribution of health professionals. It is not enough simply to train more health professionals. The additional professionals must be in appropriate fields and practice in areas where they are needed. The Committee expects that assistance will go to new schools which actively seek to train professionals for practice in the primary care medical specialties and in areas which are less well served. The Committee believes that schools which are organized in new ways and whose curricula vary from the traditional pattern are now more likely to produce the new practitioners so needed by the nation. The program now being developed at Morehouse College is an example of the sort of program which will be supported by the revised startup authority."

The plans of the School of Medicine at Morehouse College are to develop from a two year school of basic medical sciences to a four year M.D. degree granting institution by 1985. (i.e. the entering class of September 1981 will be the first class to complete their entire undergraduate medical education program within our institution).

It is in the context of both commitment and challenge that I am pleased to submit this testimony. Commitment to the goal of becoming a leader in medical education in the U.S.; to discover and promulgate new biomedical knowledge; to find better ways to organize and to deliver health care in a more humane, cost-effective and efficient manner; to provide more emphasis on preventive measures, health promotion and the conservation of health in the general population.

Our charter class of 24 students will be transferring in the summer of 1980 to affiliated medical schools at Emory University, the Medical College of Georgia, Howard University, Meharry Medical College and the University of Alabama at Birmingham.

The School of Medicine has a total of 26 full-time faculty in the basic medical sciences (anatomy, biochemistry, physiology, pathology, pharmacology, behavioral sciences), in the clinical sciences of internal medicine, community medicine/family practice and psychiatry.

The projected school enrollment, by class and by year, is shown in Table I. It should be noted that pending approval from the Liaison Committee on Medical Education, the class enrollment for September, 1980 is expected to be increased to 32 students. According to the anticipated increase in our enrollment, the initial third year class of the School of Medicine at Morehouse College will be forty-eight by 1983.

The need for greatly increased numbers of under-represented minorities in medicine and other health sciences is a national need which must be met with national resources. Therefore, the School of Medicine at Morehouse College strongly supports the recommendations from the Consortium of Minority Health Professions Schools, and, urgently recommends that these proposals be included in the reauthorization of the Health Manpower Act.

However, as a developing basic medical sciences school, which opened in September, 1978, the School of Medicine at Morehouse College, like previous new two year medical schools, has particular needs for facilities and conversion support for the development of the third and fourth clinical years.

C. Facilities for Medical Education

The School of Medicine at Morehouse College is currently housed in interim facilities loaned by Morehouse and located on the Morehouse College campus. The classrooms, first year student laboratories and some faculty and administrative offices are housed in Sale Hall (circa, 1910); second year student laboratories and faculty research laboratories are housed in a newly constructed pre-engineered temporary building; additional faculty offices are in a renovated apartment building; the medical library is on the ground floor of Brawley Hall, a College classroom building; and remaining administrative offices are in Harkness Hall (circa, 1936), an administrative office building shared with Atlanta University.

The School of Medicine has recently raised sums for the purchase of 6.3 acres of land, adjacent to the Morehouse College campus, to serve as the basic science campus of the medical school.

Ground-breaking ceremonies to initiate the construction of the first phase of the basic medical sciences building will take place on April 18, 1980 in Atlanta, and we welcome the subcommittee's participation at these ceremonies. This $6.25 million dollar building will have some 67,000 net square feet for classrooms, student laboratories, faculty offices and laboratories, student lounge, medical library and some administrative offices. The construction of the second phase of the basic medical sciences building, which will have approximately 80,000 square feet, is scheduled to be initiated in 1981, to allow for expansion of class size to 80 students; and to provide additional space for faculty offices and laboratories, administrative offices and support services.

In order to maintain accrediation and to provide the best possible academic environment, it is imperative that construction of needed facilities proceed as soon as possible.

We would like to thank you, Mr. Chairman, and distinguished members of the Subcommittee for the construction funds which have been awarded to the School thus far. They have been invaluable to our institution.

In order for us to continue with our plan for orderly development, an for the School to maintain its accreditation, we must have funds for additional construction of needed facilities.

B. Conversion to a Four Year Medical School

Conversion support must be available if we are to succeed with the required development of the third and fourth years of medical education, as required by the accrediting committee (LCME). As distinguished members of this Subcommittee are aware, the third and fourth years of medical education are the most complex and challenging.

Conversion support would assure the successful development of a viable four year M.D. degree-granting institution, and would help to guarantee the realization of our institutional mission, to assist the nation in its efforts to increase the numbers of minority physicians for service as primary care practitioners in underserved areas.

Precedent for conversion support exists in Public Law 92-157, and has been instrumental in the development of other similarly situated medical schools in the past. Therefore, we urge the Subcommittee to approve section 103 of S.2375.

E. Comments

The leadership support from the Federal Government is justified by the fact that the School of Medicine at Morehouse College is an institution which will serve the entire nation, and was developed in response to a national need for more primary care physicians, to work in underserved areas, among our disadvantaged, poor, and minority citizens.

This support will allow our developing medical school to continue with its orderly development, and to acquire the needed facilities to insure that its educational environment will be of outstanding merit. Further, significant matching support from the private sector for program, land, facilities and the developments of an endowment will be made possible once we have received significant Federal support.

This bold initiative by a mininority institution in response to a national need (for more minority physicians to work in underserved areas) deserves to be supported, as do other similarly situated institutions. Without such support, the full development of the contribution of the School of Medicine at Morehouse

College to our nation's urgent health care needs will not be realized.

It is to meet this challenge that we urge your action and your support. This national need must have a national response.

F. Recommendations

In addition to the recommendations from the Consortium of Minority Professions Schools, which we fully endorse, we solicit your support of the following proposals addressed to the unique needs of the School of Medicine at Morehouse College, and the national need for more black and other minority physicians:

1. Approve the funding authority for construction of medical education and primary care facilities with the priorities listed in section 103 of S.2375. We urge that the sums authorized for these purposes be increased to ten million dollars. The new authority in Section III which provides assistance to two year schools of medicine to convert to degree-granting institutions, enables them to meet a requirement for accreditation.
2. Approve section 792 (a)(1), as amended by S.2375 which authorizes funding for two year schools of medicine for the conversion to M.D. degree-granting institutions. The conversion to a four year school of medicine is a requirement of the Liaison Committee on Medical Education, for continued accreditation.

G. Summary

It is important for the survival and successful development of minority health professions schools that this Subcommittee enact legislation for institutional aid to those medical schools which demonstrate the capacity and ability to respond to the national need to train more black and other minority students. These institutions are national priority institutions.

I know that the members of this distinguished Subcommittee are concerned about our institutions. I believe that you are wrestling honestly with problems that will have a tremendous impact on the minority groups of this nation. I suggest to you that for all your concerns, nothing should challenge you more than this.

In this presentation, I have shared with you my concerns and perspectives on the health manpower legislation. I have made recommendations which I feel will be of great benefit not only to the School of Medicine at Morehouse College and other minority health professions schools, but to the health status of blacks and other minorities throughout this great land. I know that this Subcommittee will go forward and lead in solving some of these problems through legislative innovation.

We stand ready to work with you in these efforts.

Thank you for this opportunity to share our views with you.

Respectfully submitted,

Louis W. Sullivan

Louis W. Sullivan, M.D.
Dean and Director
School of Medicine at
Morehouse College

TABLE I

Current and Projected Student Enrollment in the School of Medicine at Morehouse College, 1978 - 1988

Class	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89
Freshmen	24	24	32	48	64	80	96	96	96	96	96
Sophomore		24	24	32	48	64	80	96	96	96	96
Junior						48	64	80	96	96	96
Senior							48	64	80	96	96
Total	24	48	56	80	112	192	288	336	368	384	384

STATEMENT FOR THE HEALTH PROFESSIONS TRAINING AND DISTRIBUTION ACT OF 1980 (S. 2375) AND THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980 (S. 2144).

Committee on Labor and Human Resources

Subcommittee on

Health and Scientific Research

The United States Senate

Washington, D. C.

March 12, 1980

PREPARED BY:

Florida Agricultural and Mechanical University
School of Pharmacy
Tallahassee, Florida 32307

Charles A. Walker, Ph.D. - Dean

Mr. Chairman, I, Charles A. Walker, Dean of the School of Pharmacy at Florida Agricultural and Mechanical University (FAMU), welcome the opportunity to share with you our unique role and needs as a health professions school.

Our School of Pharmacy offered its first course of instruction in the Fall of 1951. To date, we have produced more than 600 pharmacists who are located throughout the United States (Table 1). They are serving the nation in various disciplines of the profession (Table 2).

FIGURE 1

FAMU PHARMACY GRADUATES

PERCENT DISTRIBUTION BY REGION IN THE UNITED STATES

REGION	PERCENT DISTRIBUTION
Northeastern	12%
Southeastern	60%
North Central	15%
Southwestern	8%
West	5%
	100%

FIGURE 2

FAMU PHARMACY GRADUATES

TYPE OF PRACTICE BY DISCIPLINE IN THE PROFESSION

TYPE OF POSITION	PERCENT
Community Pharmacy	65%
Institutional Pharmacy	15%
Industrial Pharmacy	2%
Governmental	5%
Pharmacy Education	10%
Other Careers	1.5%
Undetermined	1.5%
	100%

A majority of FAMU Pharmacy graduates are American blacks; however, approximately 100 Cuban pharmacists have received degrees from Florida A&M. The present enrollment is 316 undergraduate students, the majority of whom can be classified as under-represented disadvantaged. Seventy-five percent are American blacks, 20% are American whites, mainly from the rural areas of North Florida, South Alabama and South Georgia where health care services are minimal, and 5% are of Spanish origin. Our present enrollment consists of 54% female.

In order to reach parity, this country needs 14,000 black pharmacists. Presently, there is one black pharmacist for each 11,000 black persons compared to one non-black pharmacist for each 1,500 non-black persons. There are 72 accredited colleges and schools of pharmacy, four of which are predominantly black. For the past five years, 1974-75 through 1978-79, a total of 34,158 baccalaureate pharmacists were produced; only 1,060 were black. The predominantly black colleges of pharmacy produced 553 American black pharmacists during the past five years or better than 50% of the total (Table 3).

While Florida A&M University and Texas Southern are predominantly black pharmacy programs located at state institutions, these schools serve as extremely important national resources for health professionals. These schools, out of tradition, attract and graduate significant numbers of minority pharmacists. During the past five years, 30% of all black pharmacists have graduated from these two institutions. The graduates are located throughout the United States and are serving as health resources persons primarily for the socially and economically disadvantaged. Inadequate support for the programs is due to several factors: (1) historically, the traditional black colleges have suffered long years of financial neglect and (2) funding has and continues to be provided through the slim and inadequate liberal arts education and general university budgets. These are but some of the reasons for needed continued and expanded federal assistance.

Florida A&M University joins the other members of the Minority Consortium in requesting institutional support as an investment in our program to allow us to continue on the course that we have charted. For the past two years, FAMU has produced 18% of the black baccalaureate pharmacists in the country. We have presently enrolled 40% of the black minority M.S. candidates in the pharmaceutical sciences and 50% of the black minority Doctor of Pharmacy candidates. FAMU has the only post-baccalaureate program at predominantly minority pharmacy schools. Institutional support would allow us to continue to (successfully) produce this desperately needed health manpower personnel. Previous institutional support in the form of capitation funds did not accomplish the goal of increasing sufficiently the number of minorities, especially American blacks in the health professions. The imbalance still exists in that only about 2% of the pharmacists today are black. Institutional support for an additional specified period of time would allow our program to meet the stringent requirements of our accreditation council, maintain and graduate our present accelerated student enrollment, effectively address our student retention problem, strengthen in general institutional capabilities and develop the clinical phase of our program as was mandated for all colleges of pharmacy.

Student assistance is extremely important for minority students to realize their goal of becoming health professionals. A majority of the students at FAMU as well as a majority of the students attending other predominantly black colleges and universities are classified in the poverty category. We endorse Sections 104 through 108 in Senate Bill 2375 relative to student assistance. We feel that these programs would be helpful in allowing most students at FAMU to successfully complete a curriculum in pharmacy.

We endorse very strongly the position of the Consortium relative to expanding the Health Careers Opportunity Program (HCOP). Our experience with this program for the past four years has been extremely important in identifying and motivating students who otherwise were not cognizant of the health programs or who had inadequate academic preparation and counseling for pursuing a health science career.

New requirements for all schools of pharmacy include clinical training, a very expensive component of the curriculum. Included in the clinical component is the need for specialized laboratories relative to Drug Monitoring, Drug Literature Information and additional faculty and staff. In conjunction with the apparent present inadequate funding, predominantly minority schools have not developed many of the facilities for this required phase of the curriculum. We totally support additional construction, Section 775 in S 2144 and Section 103 in S 2375 at the recommended amount of 10 million dollars.

We appreciate the opportunity to provide input and explain our needs in an effort to continue our important mission of providing health care for several million people in this country.

STATEMENT

Submitted to the
Subcommittee on Health and Scientific Research
of the
Committee on Human Resources
United States Senate
March ~~10~~ 12, 1980

by
Anthony M. Rachal, Jr.
Executive Vice President
XAVIER UNIVERSITY OF LOUISIANA
New Orleans, Louisiana

The Chairman, and distinguished members of the Sub-committee on Health and the Environment of the House of Representatives Interstate and Foreign Commerce Committee. We are pleased to have the opportunity to make this presentation on the need for financial assistance to a National Resource, our College of Pharmacy. We respectfully contend that it is in the national interest to assure the future of this institution.

Xavier University operates the only private College of Pharmacy in the United States with the special mission of bringing more minorities into the health professions. Xavier, then is national resource that should be preserved and strengthened. Xavier in 1977-78 accounted for 61% of the total black enrollment in the 15 private Colleges of Pharmacy in the United States (108 out of 176 students). The 72 colleges of Pharmacy produced 250 Black graduates in 1978-79. 43, or 17.2%, graduated from Xavier. It educates over 10% of all the black students enrolled in the 72 Colleges of Pharmacy across the country.

Xavier's College of Pharmacy offers a quality program: over the past two years, 100% of the graduates who applied have passed the State Board Examination. But the program is costly, especially to an institution whose resources are so sparse. Mounting deficits have threatened the College's existence. In response to this crisis, we have, in addition to making appeals to alumni and private donors, sought more outside funding through federal grants available to Health Profession Schools.

Xavier has applied for and received a grant as a Health Profession School in Financial Distress each year since the Public Health Service instituted this program in 1970. Never has there been any doubt that the institution qualifies. An abundance of documented evidence confirms that we were in financial distress at the beginning of the decade. We are in financial distress now. And, we will be in financial distress through the next decade, unless some significant help is acquired.

The kind of help Xavier has received through distress grants is precisely what was needed; but, the degree of help provided thus far has not been sufficient. Under a bare bone budget, which provided minimum support to meet accreditation standards, our audited figures for Fiscal Year 1976-77 show actual expenditures exceeded income by slightly more than $177,000. Our Financial Distress Grant for that year was $74,000. In other words, we needed two and one half times the amount funded. Last year, with your help in eliminating the 75% rule, the gap for fiscal year 1979 was narrowed considerably, but we received only half of our need. We have sought funds from non-federal sources with good results, but the dollars remain inadequate for our needs.

Over the past seven years, we have cooperated with Public Health officials in drawing up realistic and workable plans to bring the institution out of its deficit state. The plans made in the early years had to be scrapped because accreditation requirements forced us to double the number of faculty for the College since 1975. These skyrocketing personnel costs, combined with the inadequate funding of distress grants in recent years, plus the fact that the Financial Distress program was being phased out, causes us grave concern for the future.

Our institutional ills are financial -- not academic or management. We have tried to utilize all the means at our disposal to solve our financial problems. Every recommendation that has come out of our on-going dialogue with the Public Health Service has been implemented; our audits have been found acceptable and the overall quality of the program has been maintained.

At one time increasing income by increasing enrollment was a feasible option. It no longer is. Enrollment is at capacity.

Our experience with tuition increases has shown that they have barely allowed us to keep pace with inflation; rising costs have minimized our chances for reducing the deficit through this route. There will, of course, be future tuition increases, but as the only private College of Pharmacy in the nation with a predominantly black low-income student body we cannot price our services beyond the reach

TABLE 3

MINORITY BACCALAUREATE GRADUATES OF COLLEGES AND SCHOOLS OF PHARMACY

ACADEMIC YEARS 1974-75 -- 1978-79

Academic Year	Total Graduates	White Americans	%	Black Americans	%	+	Hispanics	%	Native Americans	%	Asian Ancestry	%	Others & Foreign	%
1974-75	5,739	4,919	85.71	176	3.07	107	119	2.07	8	0.14	188	3.28	329	5.73
1975-76	6,645	5,872	88.37	183	2.75	86	101	1.52	11	0.17	149	2.24	329	4.95
1976-77	7,385	6,597	89.33	218	2.95	115	97	1.31	9	0.12	138	1.87	326	4.41
1977-78	7,363	6,638	90.15	225	3.06	105	111	1.51	2	0.03	150	2.04	237	3.22
1978-79	7,026	6,298	89.64	258	3.67	140	99	1.41	15	0.21	152	2.16	204	2.90
TOTAL	34,158	30,324	88.78	1,060	3.10	553	527	1.54	45	0.13	777	2.27	1,425	4.17

+ = FIGURES FROM THE 4 PREDOMINANTLY BLACK COLLEGES.

DATA COLLECTED FROM THE AMERICAN JOURNAL OF PHARMACEUTICAL EDUCATION.

of our clientele. Our current tuition rate of $2,400 per year is well below the national average $3,100 for private schools of pharmacy, but the economic status of our student is proportionately far lower than that of their peers in other institutions.

Other actions taken include acquiring state financing, improving our management system, and initiating cooperative arrangements with other institutions. Public Health Service reports show how successful the management improvement effort has been.

Following a site visit by a Task Force of the Public Health Service and reported to the Congress by the Secretary of DHEW*, we were supported in our claim to be a national resource. The Task Force also reported favorably on our programs, the operation of them and our projected budgets. Actually it recommends larger expenditures.

In summary, we have taken every reasonable step we can to avoid a condition of financial distress; we have followed as best we could the recommendations of Public Health officials, who have been understanding and helpful; and yet we are projecting a deficit of $600,000 this year.

On the attached sheets we show a projected cumulative deficit of three million, one hundred thirty-five thousand dollars through 1982. This amount includes the funding necessary to continue to meet accreditation requirements and to maintain the educational program at the high level of quality which we have achieved in the past.

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*Reports from Secretary, DHEW requested by House Report No. 95-1248 and Senate Report No. 95-1119.

We hope that our past performance and our potential are weighed carefully in granting consideration and ultimate support for the proposed legislation we seek to provide the resources necessary for this unique institution's survival. The American people could not make a sounder investment.

There are two bills under consideration by this Committee that is of great interest to us because they can help us:

Both "The Health Professions Training and Distribution Act of 1980 (S2375) and The Health Professions Educational Assistance and Nurse Training Act of 1980"contain a section designed to provide assistance to schools that suffer acute and chronicle distress. Xavier University strongly supports the Consortium of Minority Health Professions Schools recommendations regarding these bills. We believe that the Health Professions Training and Distribution Act of 1980 more accurately addresses the need of minorities institutions in providing solutions consistent with our ability to respond. While we support S2375 generally, there are specific amendments presented in the testimony by our spokeman for the Consortium of Minority Health Professions School which we recommend and for which we urge your acceptance and support.

Private Colleges of Pharmacy

(Final 3 Years Full Time Enrollment Figures from AACP for Academic Year 1977-78)

Institutions	TOTAL Students	Black Students
Samford University	321	3
University of the Pacific	423	4
University of Southern California	449	10
Mercer University	319	10
Butler University	259	1
Drake University	262	3
Northeastern University (Massachusetts)	422	0
St. Louis College	419	8
Creighton University	194	6
St. John's University	668	14
Ohio Northern University	406	2
Duquesne University	367	2
Philadelphia College	566	5
Xavier University	223	108
	5298	176

XAVIER UNIVERSITY OF LOUISIANA

COLLEGE OF PHARMACY

Summary Schedule

No.	Fiscal Year Date	Current Fund Revenues	Current Fund Expenditures	Surplus (Deficit) *	* Percent of Budget
ACTUAL					
1	76 - 77	$ 710,708	$ 963,172	$(252,464)	26.2%
2	77 - 78	891,758	1,187,030	(295,272)	24.9%
3	78 - 79	982,890	1,367,807	(384,917)	28.1%
CURRENT					
4	79 - 80	983,250	1,583,760	(600,510)	37.9%
PROJECTED					
5	80 - 81	1,078,000	1,710,360	(632,360)	37.0%
6	81 - 82	1,203,000	1,873,600	(670,600)	35.8%
7	82 - 83	1,354,000	1,995,610	(641,610)	32.2%
	TOTAL	$ 7,203,606	$ 10,681,339	$ (3,477,733)	32.6%

October 1, 1979

XAVIER UNIVERSITY OF LOUISIANA - COLLEGE OF PHARMACY

Statement of Current Fund Revenues, Expenditures & Transfers
for the Seven Year Period Ending June 30

	76-77 (1)	77-78 (2)	Rate of Change %	78-79 (3)	Rate of Change %	79-80 (4)	Rate of Change %	80-81 (5)	Rate of Change %	81-82 (6)	Rate of Change %	82-83 (7)	Rate of Change %	TOTAL 7 YEARS	Ref. Nos.
CURRENT FUND REVENUES															
Tuition & Fees	439,744	512,022	16.4	540,454	5.6	600,000	12.5	675,000	11.0	775,000	14.8	835,000	6.5	4,379,220	1
Gifts	39,400	6,976	(76.2)	91,226	1207.7	30,000	(67.1)	45,000	50.0	50,000	11.1	100,000	1.0	352,602	2
Federal Capitation	71,793	91,616	27.6	79,093	(13.7)	64,000	(19.1)	45,000	(29.0)	30,000	(33.3)	35,000	16.7	406,504	3
Sponsored Programs (Direct Expenses Recovered)	144,461	253,092	75.0	245,127	(3.0)	250,000	2.0	275,000	10.0	300,000	(89.1)	350,000	16.7	1,818,400	4
State Capitation	25,250	27,250	7.9	25,250	(7.3)	28,750	13.7	35,000	21.7	45,000	28.6	50,000	11.1	236,500	5
Other Sources	- 0 -	- 0 -		1,700		2,300	43.7	3,000	30.0	3,000	0.0	4,000	33.3	14,240	6
TOTAL REVENUES	710,709	891,756	25.5	982,080	10.2	983,250	0.03	1,078,000	9.6	1,203,000	11.6	1,354,000	12.6	7,202,880	7
CURRENT FUND EXPENDITURES															
Salaries & Fringe	401,750	499,196	24.3	572,383	14.7	694,000	21.2	814,000	17.3	890,000	9.3	951,560	6.9	4,822,837	8
Student Wages	30,991	42,110	35.9	56,126	33.3	57,000	1.6	59,000	3.5	62,000	5.1	65,000	4.8	372,236	9
Travel	19,706	19,931	1.1	29,245	46.7	32,000	9.4	35,000	9.4	38,000	8.6	40,000	5.3	213,884	10
Equipment	17,293	18,900	9.0	65,547	245.3	38,000	(42.0)	40,000	5.3	45,000	12.5	50,000	11.1	274,020	11
Supplies	55,002	50,949	(7.4)	70,467	38.3	65,000	(7.8)	70,000	7.7	75,000	7.1	80,000	6.7	466,418	12
Utilities	31,491	42,636	35.5	44,000	3.4	55,000	22.3	65,000	18.2	80,000	23.1	90,000	12.5	489,129	13
Renovations	- 0 -	- 0 -		13,009		45,300	229.9	10,000	(77.9)	10,000	0.0	- 0 -	(1.0)	78,009	14
Other Expenses	37,513	61,573	64.1	18,743	(69.6)	10,000	(46.6)	15,000	50.0	15,000	0.0	15,000	0.0	172,827	15
Institutional Services	281,248	369,494	29.3	417,048	13.1	512,560	17.1	462,300	13.3	498,600	9.2	704,110	6.2	3,531,121	16
TOTAL EXPENDITURES	879,994	1,104,006	25.7	1,289,160	16.7	1,509,860	17.1	1,710,300	13.3	1,873,600	9.5	1,995,610	6.5	10,362,083	17
MANDATORY TRANSFERS															
Principal	70,000	70,000	0.0	70,000	0.0	70,000	0.0	- 0 -	(1.0)	- 0 -	0.0	- 0 -	0.0	280,000	18
Interest to Date	14,159	12,222	(13.7)	9,847	(19.1)	4,200	(51.3)	- 0 -	(1.0)	- 0 -	0.0	- 0 -	0.0	39,297	19
Total Exp. & Transfers	963,173	1,187,029	23.1	1,367,997	15.2	1,583,760	15.8	1,710,300	8.0	1,873,600	9.5	1,995,610	6.5	10,681,229	20
SURPLUS OR (DEFICIT)	(252,464)	(295,273)	17.0	(384,917)	30.4	(600,510)	56.0	(632,300)	5.3	(670,600)	6.0	(641,610)	(4.3)	(3,477,733)	21
FINANCIAL DISTRESS FUNDS	74,119	167,757		321,334		1,047,089		632,300		670,600		641,610		3,554,069	22
Adj. Surplus or (Deficit)	(178,345)	(127,516)		(63,583)		446,579		- 0 -		- 0 -		- 0 -			
Cumulative (Deficit)	(255,481)	(382,996)		(446,579)		- 0 -		- 0 -		- 0 -		- 0 -			

Senator SCHWEIKER. Now we will call on our fifth panel: Charlie Clements, president, American Medical Student Association; Stuart M. Ginsberg, representing the American Student Dental Association.

STATEMENTS OF CHARLES CLEMENTS, PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION, AND STUART M. GINSBERG, REPRESENTING THE AMERICAN STUDENT DENTAL ASSOCIATION

Mr. CLEMENTS. I am a fourth year medical student and serving as president of the American Medical Student Association. AMSA has over 20,000 members at 134 medical schools throughout the country. It is an honor to be here.

Student assistance is one of the most serious problems facing us today. Our profession is in danger of returning to an elitist group. Recent statistics have shown that students from families of lower middle incomes—the children of farmers, craftsmen, sales clerks, and others in the $10,000 to $20,000 income a year range—are gradually disappearing from the Nation's medical schools. Minority admissions have leveled off and [illegible] percentage are actually declining. Some medical schools are beginning to move toward basing their admissions on applicants' ability to pay.

We are not here looking for handouts. We know our professions will eventually place us in high income brackets. We are concerned about trends that will destroy the altruism that motivated us to enter medicine. With tuition at $13,500 and allowing a modest $6,500 for annual living expenses, students at Georgetown University can graduate with over $80,000 in debts.

Because of the structure of most loan programs, many may not enable them to service those debts while in residency training. Theirs is not an atypical situation; we already have reports of several medical residents dropping their training programs because they were unable to meet their debt obligations.

We favor a needs-based financial assistance program to allow all students to cover tuition and living expenses. The theory of private sector leverage looks good but has not always served the needs of low-income and disadvantaged students, because banks don't find them attractive markets or interest rate guarantees are so quickly left behind by inflationary spirals that banks are reluctant to commit limited funds.

We are concerned about the mood of the economy and what that may dictate if you depend upon the private sector.

Exceptional financial need scholarships are essential to attract low-income and disadvantaged students into medical schools. These students may be hesitant to enter into large debts if they are not confident about the ability to face the rigorous and demanding curriculum ahead. We urge this minimally funded program be expanded.

We support the concept of a service contingency as a quid pro quo for a low-interest subsidized program if it does not include the military as an option. A service contingency with a broad range of options, including research if that becomes a national priority, is attractive.

We strongly support the loan forgiveness for practice in shortage area concept. There are many students who want to return to the communities from which they came. I urge you to look at the 20 years of failure of both Federal and State loan forgiveness programs. A student $50,000 in debt is not going to consider going into a shortage area where his or her income in early years of practice is likely to be meager in return for 2 years of $500 a month loan forgiveness. If you want people to enter private practice in shortage areas, there must be incentives that reflect the risks and difficulties of such undertakings.

Any loan or loan forgiveness program should have an income-based repayment schedule. Upon completion of medical school, students still face 3 to 5 years of residency. Loan repayment schedules must reflect the realities of medical training, which means deferrment of interest while in training. I would like to emphasize we do not want our schooling paid for, but we do not want to drive idealistic physicians into high-paying specialty or geographic areas because the expensive model of medical education in this country.

INSTITUTIONAL SUPPORT AND SPECIAL PROJECTS GRANTS

We feel medical schools need a stable source of financial support whether it be called capitation or special project grants. The important point about capitation is that its original purpose was successfully served: increasing the number of medical students.

Since national priorities have changed, it would seem logical to use this successful model to meet those needs. Let those institutions who do not want to help meet national needs crying academic interference decline those. But for those schools who are helping, stable funding as a quid pro quo would seem appropriate. If there are several options for helping to meet national priorities through special projects, schools should not feel coerced and can make important choices for themselves.

Why would a capitation model not be used to encourage schools into meeting priorities of greater enrollment of minorities and women?

A few institutions are now bearing the brunt of producing a majority of the country's minority physicians. Those institutions are a national resource and recognition of this should be reflected in baseline institutional support.

Medical schools with over 12 percent minority enrollment or over 40 percent women enrollment should receive additional institutional support beyond capitation. There needs to be a strong support to increase the minority pool by better preparation and motivation of students at the high school and undergraduate college level. We have spent millions of dollars in attempts to do this and we must critically evaluate which attempts were successful and why.

Many of the curriculum changes which were stimulated by Federal moneys resulted in mere add-ons to an already overcrowded curriculum. We feel it is important to provide special moneys for innovative curriculum, not just course changes, because the whole model of our medical education should be under question.

If the new physician is to learn to be an advocate for health and not just a technician treating disease, then our education must change. There should be funding for those who want to attempt that challenge. We strongly support many of the special projects that are contained in both Senate bills. We feel incentives should be based upon performance, not just opportunity. If geriatrics is, indeed, important, a certain percentage of a school's graduating class should have had a course or clerkship in geriatrics.

NATIONAL HEALTH SERVICE CORPS

Since 1975, when NHSC scholarships were increased and all other forms of student aid were reduced, we have seen increasingly large numbers of scholarship recipients at high tuition schools. Schools which have no commitment to primary care or shortage area of practice. How can students adequately prepare themselves for service ahead if their institutions feel no obligation to assist them?

The NHSC needs to attract people who are interested in service, not financial aid. Having other types of assistance available will help, because students who do want to serve won't be competing with those who want only aid.

We support continued expansion of the NHSC. We would ask you to be skeptical of those who say it is competing with private practice. At the height of its projected expansion in 1985, it will only have less than 1 percent of the Nation's practicing physicians.

Surely there is more than 1 percent of the country that will not support a physician in private practice. We would be skeptical of those who claim that Corps physicians are expensive because they are not as productive as private practitioners.

There are young physicians practicing in targeted difficult areas; they are often setting up practices and the populations they serve are often poor and haven't previously had adequate health care—all of which makes for less productivity.

We would also be skeptical of those who say corps physicians are competing with private practitioners in inner cities. We ask you not to confuse numbers of physicians with access to physicians particularly for those on medicaid or medicare.

The Corps itself needs increased funding to provide the communication, nurturance, and preparation of its assignees during the long 7 years between entering medical school and beginning to serve a community.

Medical care for millions of Americans would not be provided without the National Health Service Corps. Over 25 percent or 700 counties are designated health manpower shortage areas, 138 of which have no medical providers at all. We think the 40 million Americans who live in those areas deserve adequate health care and need the National Health Service Corps.

Thank you.

Senator SCHWEIKER. I am glad, Stuart, we are having our hearing to coincide with your spring vacation.

Mr. GINSBERG. Thank you.

My name is Stuart M. Ginsberg, and I am a third-year student at the University of Pennsylvania School of Dental Medicine. As legislative representative of the American Student Dental Association, ASDA, I am pleased to have this opportunity to testify on behalf of the 17,000 dental students who are members of the organization.

It is well known that tuition costs and related educational expenses have skyrocketed for undergraduate and graduate schooling.

Nowhere is this trend more evident than in the health professions schools. Indeed, the average tuition for all American dental schools increased over 142 percent in just the past 6 years.

In the past year alone, first year dental students at Fairleigh Dickinson University were assessed a 50-percent rise in tuition. During the previous 2 academic years, tuition hikes of 51 percent at Northwestern University Dental School and 47 percent at Georgetown University School of Dentistry were approved.

In addition, the magnitude of the total annual education costs facing today's dental student is staggering. First-year dental students at the University of Pennsylvania in 1979 faced total educational costs of $16,400. The total expenses confronting first-year students at Tufts University and Georgetown University are approximately $20,000. The students at Tufts University are currently paying over $10,000 annually and expect to pay over $12,000 for 1980–81 for tuition alone.

Complicating this foreboding financial picture, is the fact that the financial aid resources available to dental students are extremely limited. Less than 15 percent of the total funds raised by the 1978 dental school graduates surveyed was provided by scholarships and grants. Less than 2 percent of the dental students who graduated in 1979 received financial aid through the National Health Service Corps scholarship program.

These factors all contribute to the current situation where Federal student loans are heavily relied upon as the primary source of funding to meet the immediate costs of professional school.

For example, in academic year 1978–79, 94 percent of all dental students attending New York University received loan funds.

The result of this heavy reliance by dental students on educational loans, coupled with the enormous tuitions and related education costs has been twofold:

First, the AADS has reported that there has been a significant decline in the number of dental school applicants. It is particularly disturbing that a major contributing factor in this decline has been the decline in applicants from the socioeconomic lower middle class. The second result is that recent dental school graduates have been burdened with huge and escalating debts.

In a recent survey of the 1978–79 senior class at the University of Pennsylvania, the average debt of graduates was found to be $26,000. The smallest debt reported by a respondent to this survey was $16,000, with other debts ranging as high as $45,000.

The ASDA believes that some of these concerns have been addressed by the proposals offered by Senators Kennedy and Schweiker. The ASDA appreciates the significant present and past efforts by both Senators on behalf of improving the health education system in this Nation, and believes that by utilizing these bills as a basis for debate, a reasonable solution can be achieved.

Although the measure, S. 2375, introduced by Senator Kennedy, includes a number of positive features which address many of the concerns expressed earlier, the ASDA is not prepared to endorse any student assistance program which is contingent upon service after graduation.

Although we are not in agreement with several of the specific provisions of S. 2144, we prefer the direction Senator Schweiker has taken.

We are particularly pleased with the inclusion of a graduated repayment plan, and significantly increased annual and cumulative loan limits.

We believe, however, that the significant increases in interest rates provided by this bill, and the absence of a total in-school interest subsidy program will merely serve to continue the upward spiral of debt burdens, and perpetuate the current crisis in financing dental education.

The ASDA recommends that any new health student assistance plan include a program consisting of several components rather than a single mechanism.

We believe that the bulk of student assistance should be provided in the form of direct Federal loans, to assure access to aid, and stabilization of interest rates.

This loan program should continue the current reasonable interest provisions of the HPSL program, and include graduated repayment options to help manage the large debts upon graduation.

If a federally insured loan authority is to be included within a renewal of the manpower law, it should be considered only as a mechanism of last resort, and not as the principal vehicle of student assistance.

The third component of student assistance programs should be a continuing scholarship program for students demonstrating exceptional financial need. We believe that this program should not merely support such students for 1 year, but should be funded adequately to provide support throughout dental school.

We applaud Senators Kennedy and Schweiker for their responsiveness to our needs and their timely introductions of bills to address these concerns. We are confident that a realistic, well-conceived program of student assistance can be developed to alleviate the current crisis in financing dental education.

Thank you.

Senator SCHWEIKER. Mr. Ginsberg, I notice in your statement, you favor an alternative to the National Health Service Corps in meeting dental needs of underserved areas.

Do you have some specifics as to what these alternatives might be and why they are preferable?

Mr. GINSBERG. ASDA believes there are some areas of the country that will need some type of service corps, but to a much smaller degree than it is currently thought.

We believe that the private practice system is able to handle the burden of providing care to the country. However, we do not believe that it has been successfully examined in the past.

Let me give you an example in Minnesota.

There is a new network called National Health Professions Placement Network. This is a computerized data matching network that matches students and underserved areas. It has proven most successful in Minnesota utilizing private-practice mechanisms to reduce the number of underserved areas to a bare minimum.

Along with you, we believe that possibly the best idea is to transfer to the States some of the responsibility of providing some sort of health service care. We believe that the Federal Government at the present time really should not be providing direct primary care to people to the extent that it is expanding.

Senator **Schweiker**. Mr. Clements, the administration proposal would leave students with a choice between service commitments under the National Health Service Corps, and market loan rates which apparently at current interest rates now might be 18 percent interest.

Do you believe this will force students to take scholarships who have no interest in practicing in an underserved area and they will find some way of reneging on that commitment after they make it?

Mr. **Clements**. I think that depends on the level of loans available at the market rate.

In 1975, when we encouraged the Congress to end capitation and to funnel that money into the Corps, what we found was because all financial aid programs were cut at the same time, students were coerced into the Corps, and we have a number of students at high tuition schools and students not interested in service who want financial aid.

I think if enough financial aid is available at market rates, students who want to finance their own education will do that, and those who want to serve will enter the Corps.

Senator **Schweiker**. I do not know if you heard the figures from yesterday, but if you took the Administration's figures, where they assume a 12-percent interest rate, my recollection is that a student, after he finishes his medical education, would have to pay back some $234,000, nearly a quarter of a million dollars at a 12-percent interest rate.

Do you think students would be prepared to do that?

Mr. **Clements**. I think that kind of debt is going to force more people into higher-paying specialty and geographic areas.

Senator **Schweiker**. In fact, if you figured the rate based on 18 percent interest, it would be almost $400,000. I do not know where the rate is going to be; nobody knows at this point. Nobody thought it would be 18. Who knows where it is going to go? The debt jumps to about $400,000 that we would be saddling students with if we take off the interest ceiling cap and as the administration proposes tried to finance three-quarters of our medical students through that system.

Mr. Ginsberg, maybe you want to comment on that, too.

Mr. **Ginsberg**. We are extremely concerned over two vital points with respect to debt burdens.

First of all, as I have said, there have been significant declines in the number of applicants to dental schools, particularly in the lower socioeconomic classes. We are afraid that the high price of dental schools right now is closing out this option for many of these lower socioeconomic students. In addition, we share the medical students' concern that practitioners will then locate in more lucrative practice settings, thus compounding the twin problems of geographical maldistribution and rising health care costs.

Senator **Schweiker**. It's sort of instinctive to want to pay off your debt as soon as you can. It has got to be burdensome and worrisome to have such a debt. You want to have an opportunity to pay off in the quickest way would be my reaction.

Mr. **Ginsberg**. Under the age of 30, the income level of dental graduates is not high compared to the profession as a whole. We are probably talking about less than $30,000 income level for a considerable period after school, which compounds the problem.

Senator **Schweiker**. Maybe you might repeat, Mr. Ginsberg, the tuition costs again, just highlight those costs.

Mr. **Ginsberg**. On a percentage basis, tuitions have risen at dental schools, all American dental schools, over 142 percent in the past 6 years.

Currently, at Tufts University, first-year students are paying over $10,000, and it appears they will be paying close to $12,000 for 1980–81.

Senator **Schweiker**. That is tuition, not living expenses?

Mr. **Ginsberg**. Simply tuition.

On top of that come several thousand dollars of instruments which are required, books and, of course, living expenses. Therefore, $20,000 or $22,000 is not an unrealistic yearly estimate.

Senator **Schweiker**. At Tufts?

Mr. **Ginsberg**. At Tufts.

Senator **Schweiker**. What would be comparable at Penn?

Mr. **Ginsberg**. Penn is approximately $16,400, probably over $18,000 next year.

Senator **Schweiker**. Tuition is what?

Mr. **Ginsberg**. Tuition right now is $8,600. Next year it will be closer to $10,000.

Senator **Schweiker**. Mr. Clements, how about you on those same questions?

Mr. **Clements**. Average figures for private medical schools are about $10,000 for tuition and for State less than that. I mentioned Georgetown at $13,500 for just tuition. There are several in the $11,000 to $12,000 range also. They are climbing all the time. Tuition seems to be exempt from inflationary guidelines.

Senator **Schweiker**. A lot of things seem to be exempt from the inflationary guidelines unfortunately.

What is your school?

Mr. **Clements**. University of Washington.

Senator **Schweiker**. What is that?

Mr. **Clements**. That is about $1,500 a year.

Senator **Schweiker**. That is State supported?

Mr. **Clements**. That is a State-supported institution.

Senator **Schweiker**. What are the living expenses?

Mr. **Clements**. Living expenses there would be, including books, about $6,000 a year.

Senator **Schweiker**. Thank you both very much. We will take into consideration your comments. I think you both have been very constructive.

Our last witness today is Dr. William Ruhe, senior vice president, American Medical Association.

Dr. Ruhe?

STATEMENT OF C. H. WILLIAM RUHE, M.D., SENIOR VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, AMA DIVISION OF LEGISLATIVE ACTIVITIES

Dr. RUHE. My name is C. H. William Ruhe, M.D., and I am a senior vice president of the American Medical Association. With me is Harry N. Peterson, director of the AMA's Division of Legislative Activities. I am pleased to have the opportunity to present the views of the AMA on Federal health manpower legislation.

We have a statement for the record, which we will submit.

Senator SCHWEIKER. We will be pleased to insert it, without objection.

Dr. RUHE. I will present excerpts from it and be glad to respond to any questions.

Support for medical education and health manpower training is a responsibility to be shared by all segments of our society. Federal and State government support is an appropriate activity, and such support can provide a foundation for the maintenance of our strong medical educational system which is the best way to assure that medical and other health services of high quality will be available.

Two factors are singularly important to assuring the strength of the educational system: First, the institutions themselves must have sufficient resources to provide education of high quality; and, second, the students who wish to pursue careers in health professions must have the resources to meet the costs of this education. Government support must exist to bridge the gap between the limits of private resources and the total costs of medical education.

INSTITUTIONAL SUPPORT

Medical schools should receive support from multiple sources, both nongovernmental and governmental. Governmental funds should be available for a variety of purposes and we recommend that several types of governmental programs be used to provide financial support where it is most needed.

Unrestricted general institutional support has been a valuable investment of public funds to improve the quality and availability of medical education and therefore medical care. Since medical schools use these funds according to the specific needs of the schools and the communities they serve, the importance and effectiveness of these funds are much greater than their relatively small size might indicate.

A second source of medical school support should be in the form of special projects grants. With special project grants each institution may judge whether it can and should participate, based on factors such as curriculum strengthening, community needs, as well as other factors. Also, the Government has the option of awarding grants for a variety of activities, including those deemed to be of national or local importance. Since participation is voluntary, each school can choose those grants best suited to a variety of its unique characteristics.

Previous health manpower legislation placed emphasis upon the development and construction of medical school facilities. Modernization of existing facilities is now essential if the quality of the educational programs is to be maintained.

As one method to meet this goal, we encourage a system of Government guaranteed loans, along with interest subsidies, as the most effective means of generating funds for modernization from private money markets.

Insofar as possible, schools should seek private financing for these projects. Government's primary role should be to stimulate the private sector to make needed funds available. However, some schools may be unable to obtain private funds. For these instances, we urge that Government serve as a lender of last resort, and funds should be available for this purpose.

The AMA also supports special assistance for schools with financial problems that threaten the quality of their programs and even their continued operation. Such assistance, however, should not become a permanent crutch for faltering schools. Rather, it should be geared to overcoming iimediate financial hurdles and lead to financial stability. Any schkol assisted in this manner must be obligated to take all necessary steps to achieve sound financial stability in a reasonable time.

STUDENT ASSISTANCE

The costs which students must now bear for their medical education have reached the point where a majority of students must seek substantial financial assistance to begin and continue their training.

We are deeply concerned by the financial pressures placed on students, and we firmly believe that access to medical education must not be allowed to become limited on the basis of income.

The great strides taken in recent years to make medical education available to various segments of our society should be allowed to continue. We are committed to seeing that financial resources are available to aspiring health professionals.

As one means of assistance, the AMA, through its foundation, operates its own loan guarantee program for medical students and resident physicians. Since the inception of this program in 1962, more than $95 million in loans have been guaranteed.

Current loans amount to $46 million and in 1979 alone, more than $4 million was guaranteed.

Our resources, however, are not sufficient to meet an ever-growing demand in the face of rising tuition costs. It is essential that Government at all levels take steps to assure students continued access to adequate resources. Student assistance must be of the highest priority for Government action relative to aid for medical education. It is important that a variety of sources for funds be available to students.

We believe that an effective mechanism for Government participation is a program of guaranteed loans. Such guarantee encourages private lenders to make money available to students and serves to minimize the strain on Government resources.

The use of guaranteed loans also enhances the ability of students and newly licensed physicians to make intelligent career choices according to their interests and capabilities. While there is pressure to control such choices according to national needs, as perceived by some, we believe that freedom of choice must be encouraged.

While we heartily endorse the guaranteed loan mechanism, we believe that at the same time additional systems can, and should, be available.

For example, contractual service arrangements—between students and resident physicians and organizations such as the Armed Forces, or other governmental services—are one option.

Scholarships for those students showing exceptional ability should be encouraged. Furthermore, financial grants-in-aid, without obligation for repayment, should be available for able but economically disadvantaged students. We encourage both the States and the Federal Government to make these kinds of options available so that students can make choices according to their needs and abilities.

The AMA encourages the continuation and expansion of loan forgiveness programs as an effective means of meeting national needs. Upon the completion of his or her education, a physician should be free to choose to repay a Government loan directly, or to participate in a program of service in some needed area in lieu of payment.

Loan forgiveness options should be realistic to accomplish their purpose. A strong system of loan repayment through service will greatly assist in meeting the needs for the provision of medical services in areas where they are not available.

Service in such areas could be fulfilled by participation in private practice, or under the auspices of a national organization such as the Public Health Service, or the National Health Service Corps (NHSC). This type of program has the principal advantages of providing students the opportunity to select a service obligation after having completed training and of providing communities with young physicians who desire to serve in such areas.

We would also recommend that repayment of student loans be deferrable during the period of medical school training, as well as through residency training where financial limitations might pose a hardship in meeting loan obligations.

Consideration should also be given to interest subsidies for a period related to the length of training. In any event, loan repayment could be related to the capacity of the individual to repay the principal of the loan, based upon the length of time following completion of medical training.

As a further alternative method of student financing, the NHSC program serves a valuable role for those students who desire to practice in underserved areas. The AMA supports the continuation of the Corps as a beneficial method of providing medical services in underserved areas.

We have actively supported the program through our Project U.S.A., a service designed to place physicians in Corps areas for short periods of time, to relieve the assigned physician on a temporary basis. At this time, we are concerned about certain aspects of the program, particularly the definition of shortage area.

In the remainder of our statement, we have comments about some of the bills which have been introduced. We will submit those for the record.

We would like to leave open the possibility of submitting further comments at a later time, since some of these bills have been introduced quite recently and we have not really completed a thorough study of them.

[The prepared statement of Dr. Ruhe follows:]

Statement
of the
American Medical Association

before the

Subcommittee on Health and Scientific Research

of the

Labor and Human Resources Committee

United States Senate

Re: Health Manpower Legislation

March 12, 1980

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Legislative Department
Public Affairs Division
(312) 751-6513

STATEMENT
OF THE
AMERICAN MEDICAL ASSOCIATION

before the

Subcommittee on Health and Scientific Research

of the

Labor and Human Resources Committee

United States Senate

Re: Health Manpower Legislation

March 12, 1980

Mr. Chairman and Members of the Committee:

My name is C.H. William Ruhe, M.D., and I am a Senior Vice President of the American Medical Association. With me is Harry N. Peterson, Director of the AMA's Division of Legislative Activities. I am pleased to have the opportunity to present the views of the AMA on federal health manpower legislation.

In the area of medical education, it is in the best interests of medical schools, government, the medical profession, and especially patients that the relationship between government and medicine be as constructive as possible. Collectively our paramount concern and goal must be the provision of high quality medical care. The AMA encourages actions promoting this goal.

Support for medical education and health manpower training is a responsibility to be shared by all segments of our society. Federal and state government support is an appropriate activity, and such support can provide a foundation for the maintenance of our strong medical educational system which is the best way to assure that medical and other health services of high quality will be available.

Two factors are singularly important to assuring the strength of the educational system: first, the institutions themselves must have sufficient resources to provide education of high quality; and second, the students who wish to pursue careers in health professions must have the resources to meet the costs of this education. Government support must exist to bridge the gap between the limits of private resources and the total costs of medical education.

General Discussion

Institutional Support

Medical schools should receive support from multiple sources, both non-governmental and governmental. Governmental funds should be available for a variety of purposes and we recommend that several types of governmental programs be used to provide financial support where it is most needed. Unrestricted general institutional support has been a valuable investment of public funds to improve the quality and availability of medical education and therefore medical care. Since medical schools use these funds according to the specific needs of the schools and the communities they serve, the importance and effectiveness of these funds are much greater than their relatively small size might indicate. Should general institutional support be lost, two immediate results can be anticipated: first, schools would have to seek other sources of funds, possibly through tuition increases; and second, the quality and the availability of medical education would suffer.

General institutional grants should be only one of various mechanisms for medical school support. The amount of these grants, however, need not be large in relation to the school's financial income. Their proportional value is based more on their flexibility in use, as determined by individual schools, than on the absolute amount of funds available. Moreover, such funds, which add to the stability of the medical school, need not be tied to the existing program of "capitation" grants.

A second source of medical school support should be in the form of special project grants. With special project grants each institution may judge whether it can and should participate, based on factors such as curriculum strengthening, community needs, as well as other factors. Also, the government has the option of awarding grants for a variety of activities, including those deemed to be of national or local importance. Since participation is voluntary, each school can choose those grants best suited to a variety of its unique characteristics.

Previous health manpower legislation placed emphasis upon the development and construction of medical school facilities. Modernization of existing facilities is now essential if the quality of the educational programs is to be maintained. As one method to meet this goal we encourage a system of government guaranteed loans, along with interest subsidies, as the most effective means of generating funds for modernization from private money markets. Insofar as possible schools should seek private financing for these projects. Government's primary role should be to stimulate the private sector to make needed funds available. However, some schools may be unable to obtain private funds. For these instances we urge that government serve as a lender of last resort, and funds should be available for this purpose.

The AMA also supports special assistance for schools with financial problems that threaten the quality of their programs and even their continued operation. Such assistance, however, should not become a permanent crutch for faltering schools. Rather, it should be geared to overcoming immediate financial hurdles and lead to financial stability. Any school assisted in this manner must be obligated to take all necessary steps to achieve sound financial stability in a reasonable time.

Student Assistance

The costs which students must now bear for their medical education have reached the point where a majority of students must seek substantial financial assistance to begin and continue their training. We are deeply concerned by the financial pressures placed on students, and we firmly believe that access to medical education must not be allowed to become limited on the basis of income. The great strides taken in recent years to make medical education available to various segments of our society should be allowed to continue. We are committed to seeing that financial resources are available to aspiring health professionals.

As one means of assistance, the AMA through its Foundation operates its own loan guarantee program for medical students and resident physicians. Since the inception of this program in 1962 more than $55,000,000 in loans have been guaranteed. Current loans amount to $46,000,000, and in 1979 alone more than $4,000,000 was guaranteed. Our resources, however, are not sufficient to meet an ever growing demand in the face of rising tuition costs. It is essential that government at all levels take steps to assure students continued access to adequate resources. Student assistance must be of the highest priority for government action relative to aid for medical education. It is important that a variety of sources for funds be available to students.

We believe that an effective mechanism for government participation is a program of guaranteed loans. Such guarantee encourages private lenders to make money available to students and serves to minimize the strain on government resources. The use of guaranteed loans also enhances the ability of students and newly licensed physicians to make intelligent career choices according to their interests and capabilities. While there is pressure to control such choices according to "national needs" as perceived by some, we believe that freedom of choice must be encouraged.

While we heartily endorse the guaranteed loan mechanism, we believe that at the same time additional systems can, and should, be available. For example, contractual service arrangements (between students and resident physicians and organizations such as the armed forces or other governmental services) are one option. Scholarships for those students showing exceptional ability should be encouraged. Furthermore, financial grants-in-aid, without obligations for repayment, should be available for able but economically disadvantaged students. We encourage both the states and the federal government to make these kinds of options available so that students can make choices according to their needs and abilities.

The AMA encourages the continuation and expansion of loan forgiveness programs as an effective means of meeting national needs. Upon the completion of his or her education, a physician should be free to choose to repay a government loan directly, or to participate in a program of service in some needed area in lieu of payment. Loan forgiveness options should be realistic to accomplish their purpose. A strong system of loan repayment through service will greatly assist in meeting the needs for the provision of medical services in areas where they are not available. Service in such areas could be fulfilled by participation in private practice, or under the auspices of a national organization such as the Public Health Service, or the National Health Service Corps (NHSC). This type of program has the principal advantages of providing students the opportunity to select a service obligation after having completed training and of providing communities with young physicians who desire to serve in such areas.

We would also recommend that repayment of student loans be deferrable during the period of medical school training, as well as through residency training where financial limitations might pose a hardship in meeting loan obligations. Consideration should also be given to interest subsidies for a period related to the length of training. In any event loan repayment could be related to the capacity of the individual to repay the principal of the loan, based upon the length of time following completion of medical training.

As a further alternative method of student financing, the NHSC Program serves a valuable role for those students who desire to practice in underserved areas. The AMA supports the continuation of the Corps as a beneficial method of providing medical services in underserved areas. We have actively supported the program through our Project U.S.A., a service designed to place physicians in Corps areas for short periods of time, to relieve the assigned physician on a temporary basis. At this time we are concerned about certain aspects of the program, particularly the definition of shortage area.

Nurse Training

The AMA supports continued federal assistance to programs of basic nurse training in order to meet the nation's nursing needs. Federal assistance should be provided to the training institution as well as to the student.

Specific Legislative Issues

Mr. Chairman, the above comments have been brief and general in nature due to the time constraints at today's hearing and to the short time available to analyze in detail the specific provisions of the legislation before the Committee. In the remaining time that is available today I will address only selected aspects of this legislation.

S. 2375 would modify the current capitation program by establishing a program of "national priority incentive grants." Under the modified program schools would be able to receive a capitation amount of $500 per student (in fiscal year 1981) plus incremental add-ons of $250 for meeting specified national priority criteria. These criteria are designed to create an incentive for medical schools to structure future classes so that they will be composed of specific percentages of individual groups including women, minorities, and residents of underserved areas. Also, a bonus would be provided if the school structured its curriculum with specific educational courses. Furthermore, the school would be eligible for increased capitation if its graduates entered specified residency training programs.

As we discussed earlier, we believe that a program of basic institutional support should be designed to provide funds to be used by the medical school to improve the quality of its program and to meet the unique needs of the school, its students, and the community it serves. The proposed program, on the other hand, would make the award of such funds conditional on specific curricula and student census criteria. We are very concerned that this program would have the effect of establishing a positive incentive to create quotas or "ear marked slots" within medical school classes. Also, by tying funding to the actions of graduates from the medical school, the medical school is being asked to direct or control the actions of its graduates, actions which are not and should not be within the control of the institution. While national goals should be reflective of conditions in our society, it is our opinion that basic institutional support should not be the vehicle for attaining such national social goals.

S. 2375 would also create a new service contingent direct loan program. Under this program health profession schools could enter into agreements with the Secretary of the Department of Health and Human Services to provide low interest subsidized loans to students who are able to demonstrate financial need. Criteria for financial eligibility would be set by the Secretary. The borrowers would have a service pay-back option in positions designated by the Secretary to be in areas of national priority based on manpower needs, and the Secretary would have the authority to conscript borrowers under this program into those areas not filled by volunteers. For a six-month period after they have completed their education, students who do not volunteer for service will risk being conscripted through a lottery program. Under extremely broad criteria in the legislation the Secretary would determine the shortage areas or national needs. Included as one of the criteria under this program would be all of the shortage areas found in the NHSC program.

While this "service contingent" loan program may serve to fulfill short-term medical needs of "priority" areas, the long-term needs of those areas will not be met by individuals who are forced into practices for which they may be unsuited or in which they are uninterested. Physicians who choose to practice in an underserved area and who desire to serve in such an area are more likely to remain in that area, providing medical care on a continuing basis in a manner which is satisfactory to both the patient and the physician.

The provisions of the legislation creating the service contingent loan program leave many critical questions unanswered. From our analysis the negative features of the program far outweigh the perceived benefits to be derived therefrom. In our view this program is fraught with inequities, including the lack of uniformity in payback requirements and the disparity in potential service settings.

S. 2144 would alter the NHSC program by cutting back on the federal authorization level and by assisting states through grants to establish state service scholarship programs modeled on the NHSC program. As we have indicated, the AMA supports the NHSC program. Rather than decreasing the strength of the Corps at this time, aspects of the program should be carefully evaluated to determine whether its objectives continue to be met appropriately. For example, the definition of "shortage area" should be examined closely. Recent figures indicate a significant disparity in the number of persons reported as living in medically underserved areas. It should be noted that during the eight-year existence of the Corps the number of shortage areas has increased, and the purported number of persons in shortage areas continues to grow. While S. 2144 would shift significant Corps responsibility to the states, the same federally determined health manpower shortage areas would be utilized for Corps placement.

S. 2144 would eliminate capitation grants to medical schools. As we discussed, the availability of unrestricted funds for institutional support substantially improves the quality of the educational program. The loss of institutional support would require schools to find additional funds from other sources, cut back on existing education programs or increase already high levels of tuition. We are concerned that the deletion of general institutional funding under S. 2144 would be deleterious to programs of medical education.

Conclusion

Mr. Chairman, members of the Committee, thank you again for this opportunity to address you. At this point, I would like to request that additional time be made available at a future date to allow an opportunity for the AMA and other interested parties to present detailed testimony on health manpower legislation. Health manpower is a vital issue and decisions made today will unquestionably impact on tomorrow and years to come. Two of the health manpower bills, S. 2375 and S. 2378, were introduced only one week ago, and the Administration's health manpower bill was introduced only yesterday. As there has not been adequate time to review this detailed and complex legislation, we urge the Committee to hold further hearings on this subject prior to any action on these bills.

Senator **Schweiker**. We will give you that option.

In a letter of January 15, 1980, to the House Appropriations Subcommittee, which has been made part of the public record there, Dr. Sammons, executive vice president of AMA, wrote, and I quote:

> We believe that while the National Health Service Corps does perform a valuable function in many areas, it has not shown itself to be a long-term solution to the difficult problems of providing continuing medical care to shortage areas, and it is undesirable for the government and for local communities to rely so heavily on short-term medical personnel for provision of needed care.

I wonder if you would elaborate a little bit on that view and suggest what alternatives you might consider to the Corps structure or changes so that we do get more permanent service as opposed to high turnover temporary service?

Dr. **Ruhe**. I think it is fair to say, Senator, that we have somewhat mixed emotions about the program. We also recognize that it is relatively early in its history and that it is going to take a while to determine the ultimate impact of the total program.

We believe that the intent of the program and its original objectives, as expressed in the legislation, are good and reasonable; that is, to provide service in shortage areas where such service is needed.

Obviously, the hope is that many of the persons who engage in practice in those areas would be encouraged to stay in those areas and thus provide permanent medical care. It is too early to tell whether that is going to be effective in the long run.

It is interesting that, in spite of the fact that the program has been in operation for a while, the number of identified shortage areas has increased rather than decreased. It is partially due to change in definition.

Senator **Schweiker**. I was going to say we have broadened the definition.

Dr. **Ruhe**. So it looks like we are fighting a losing battle in that sense. Instead of reducing the number, it is increasing. We do have some concern that the original intent of the program not be modified by other intentions or by regulation to change this to some kind of national health service program rather than a program of providing health services in a shortage area for a stated period of time.

But we do think, with closer monitoring and observation of the program and careful evaluation of the impact over a period of time, that the program is worthy of continuation, at least for the present; and we continue to support it for that reason.

Senator **Schweiker**. Thank you, doctor. I appreciate your presentation here and participation in our hearing this morning.

The Senate Subcommittee on Health and Scientific Research will stand in recess.

[Whereupon, at 12:18 p.m., the subcommittee recessed.]

APPENDIX

TESTIMONY BY SENATOR QUENTIN N. BURDICK SUBMITTED FOR THE SENATE HEALTH SUBCOMMITTEE HEARINGS ON 1980 HEALTH MANPOWER LEGISLATION
MARCH 10 AND 12, 1980

I wish to take this opportunity to highlight the need for more geriatric education in this country and to urge the Subcommitee to give this subject very careful consideration in your deliberations on health manpower legislation.

The reason geriatric education should receive attention is simple: the number of older people — and more importantly, the number of very old people — is virtually exploding. The number of Americans over 65 has risen from 4% of our population in 1900 to 11% today. By the year 2000, nearly 17% of our people will be at least 65, and a large percentage of them will be over 75.

Yet the training medical students receive in geriatric medicine today is minimal at best. Only rarely, if at all, are they exposed to the specific problems of the elderly or come in contact with elderly patients during their training. Once in practice, however, a large percentage of their patients are likely to be elderly. And with the population aging, this percentage will grow significantly. The diseases, nutritional problems, pain response, thermal sensitivity, taste, smell, and immunity of the elderly are often different from those of younger people. Much needless suffering and institutionalization could be avoided if these differences were better understood and appreciated. Better diagnosis and more precise diagnosis could do much to improve the health care of this portion of our population.

Fourteen Senators have joined me in sponsoring legislation to encourage medical schools to establish programs of geriatric education. This bill, S. 711, authorized $3 million for this purpose. I was glad to see the concept of S. 711 incorporated into Senator Kennedy's health manpower bill, S. 2374, and in to Senator Schweiker's bill, S. 2144, as well. I would hope that the final manpower bill reported by this Subcommittee will include this emphasis on geriatric education, and perhaps go even further.

The question is how best to do this, given the limitations of the federal budget. Much of the groundwork on this subject has already been done, and we do not have to look far for guidance. In September of 1978, the Institute of Medicine, part of the National Academy of Sciences, published a detailed paper on this subject, entitled, "Aging and Medical Education." I believe the recommendations contained in this study can serve as guideposts for federal efforts to encourage geriatric education. The recommendations are concise, and I would like to include them here. They are:

> --that medical schools include appropriate content on aging in basic and clinical science courses, and establish a complementary required course that integrates knowledge about aging and the problems of the elderly;
>
> --that preparation for care of the aged be included in clinical clerkship and in housestaff training programs, as well as in examinations for certification and licensure;
>
> --that nursing homes and other long-term care facilities be included in clinical rotations for medical students and housestaff. Experience with home health programs and other alternatives to institutionalization is also desirable;
>
> --that teaching about aging receive increased emphasis in continuing medical education (CME), and that the Liaison Committee on Continuing Medical Education and its sponsoring organizations support increased geriatric content in CME programs;
>
> --that medical schools develop a cadre of faculty to teach gerontology and geriatrics to medical students and housestaff, and that a) post-residency training or fellowship programs be developed in settings that have either the necessary leadership in geriatric medicine or have a potential for promptly developing it, and b) that a limited number of career development awards in gerontology and geriatrics be established;
>
> --that a formal practice specialty in geriatrics not be established but that gerontology and geriatrics be recognized as academic disciplines within the relevant medical specialties;
>
> --that efforts to meet the educational needs of medical directors of skilled nursing facilities (SNFs) be assumed jointly by medical schools and SNFs; and,
>
> --that funding be expanded in various aspects of aging research including basic biological and behavioral sciences, clinical medicine, and health services research.

Although the Institute study focused on physician education, the study made it clear that geriatric education should not be limited to physicians, alone. Each health profession that works with the elderly provides unique services that vary with the age of the patient. Nurses, pharmacists, podiatrists, and optometrists all should be knowledgeable about geriatrics and how the aging process can be affected, for better or for worse, by their care.

In conclusion, I again urge that this Subcommittee keep the need for geriatric education in mind. It may be that S. 711 is not the perfect mechanism to achieve this goal. But the concept of the bill is sound. As long as the federal government provides medical schools money as an incentive to meet national needs, the government should provide money for geriatric education, because there is no doubt that it is a national need, both now and for the future.

STATEMENT
OF
THE CONGRESSIONAL BLACK CAUCUS HEALTH BRAIN TRUST MANPOWER TASK FORCE
ON
LEGISLATION TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND PROGRAMS OF ASSISTANCE UNDER TITLE II OF THE PUBLIC HEALTH SERVE ACT

PRESENTED TO

THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE
UNITED STATES SENATE

BY

Harley E. Flack, Ph.D.
Co-Chairperson, Health Manpower Task Force, Congressional Black Caucus
Health Black Trust

Tuesday, March 25, 1980

1. INTRODUCTION

The Congressional Black Caucus Health Brain Trust Manpower Task Force is pleased to provide this written testimony concerning S. 2375. Of special concern to the Manpower Task Force are those elements of the aforementioned proposed legislation which relate to the representation of minority peoples in the health professions training and the attendent implications for the health care status of minority individuals.

A recent publication of the Health Resources Administration, The Health Status of Minorities and Low Income Groups, set forth the hypothesis that one of the major factors contributing to the relatively lower health care status of minority peoples was their lack of representation in health care delivery and, parenthetically, health manpower training. The Health Manpower Task Force embraces this hypothesis as a step in the right direction while at the same recognizing that increasing the degree of representation of minorities in health manpower training and practice will not in and of itself automatically bring about the Caucus' goal of parity of health care status between minority and non-minority populations of this country.

The above mentioned publication also cites three major factors which seemingly influence the utilization of health services. These three factors have great import with respect to analyzing the utilization of health services by minority persons. These three factofs are: (1) the relationship between utilization and health needs and health status, (2) access and (3) the attitude of the individual toward his/her health and toward the health care system. It is the considered opinion of the

Health Manpower Task Force that increasing the representation of minority peoples in the health care delivery system vis-a-vis increasing the rate of minority enrollment and retention in health manpower training programs will serve as a catalyst for improving the attitudes of both the seekers and delivers of services, while also enhancing access. Thus, the health care needs of minority people would tend to find better definition and hence utilization patterns of these groups would improve, resulting in improved health care status.

The remainder of these remarks attempt to address the issues associated with increasing minority enrollment and retention in health professions training from the following perspectives: (1) the data base of minority student enrollment in health professions training programs, (2) a review of past and current efforts (PL 94-484) which have been employed to attempt to address the above issues, (3) comments and recommendations on those elements of S. 2375 which attempt to address these issues of increasing minority enrollment and retention in health professions training programs in our country.

2. DATA BASE

Dr. Lavonia Allison of the University of North Caroline has discussed several problems which are inherent in attempts to collect data on the representation of minorities in health professions training programs and in the professions themselves. Among these problems are the following: (a) current federal laws which protect individual rights and prohibit discrimination on the basis of race and sex, (b) difficulty in analyzing certain health fields because of the breadth of individual occupations comprising the fields, e.g. allied health, and (c) difficulties associated with "teasing out" key variables, e.g. regionalization, manpower distribution patterns and the impact of minority institutions in the training process.

The above problems not withstanding, the CBC Health Manpower Task Force has attempted to compile and present what it believes to be the most accurate data regarding the enrollment of minority students in six key professional areas, i.e., Dentistry, Medicine, Allied Health, Nursing, Pharmacy and Optometry.

2.1. Dentistry*

The enrollment data for dentistry has been analyzed by Dr. Joseph Henry, former Dean of the Howard University College of Dentistry. The column headed "total first year students" reveals that entering class size increased steadily from 4,705 in 1971 to 6,301 in 1978. This is an increase of 26 percent. The column headed "Black" reveals that Blacks entering dental school in 1971 numbered 245 and this peaked at 298 in 1975 and declined to 280 in 1978, a net increase of 14%. Thus, for this period, the increased production of dentists generally has been at a rate almost double that for Blacks, which was a specially targeted group for increase in numbers. More frightening is the fact that Blacks declined from 5.2% of the entering class in 1971 to 4.4% of the entering class in 1979. It appears that the figures have shown a further decline of Blacks in the 1979 entering class. The reasons for these findings are complex. Factors such as the Bakke decision, reduced capitation, increased tuition and fees, less scholarships and loan funds, high costs loans (HEAL), a poor feeder and recruitment system, lack of sufficient role models, Erosion of commitment:

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* Taken from the paper by Dr. Joseph Henry, Harvard School of Dental Medicine. Delivered on September 21, 1979, CBC Health Manpower Task Force Workshop.

TABLE 1

MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL
ACADEMIC YEARS 1971-72 THROUGH 1978-79 1/

Academic year	Total first year students	Black	Racial/ethnic category American Indian	Mexican-American	Puerto Rican	Oriental (Asians)	Other minority	Total minority	Percent minority of total first-year students
1971-72	4,705	245 (5.2%)	4	27	13	112 (2.4%)	11	412	8.8
1972-73	5,287	266 (5.0%)	5	53	3	138 (2.6%)	10	475	9.0
1973-74	5,389	273 (5.3%)	12	64	5	141 (2.6%)	34	529	9.8
1974-75	5,555	279 (5.2%)	12	68	7	142 (2.6%)	43	551	9.9
1975-76	5,697	298 (5.2%)	22	64	11	186 (3.2%)	56	637	11.2
1976-77	5,869	291 (5.0%)	21	81	15	174 (3.0%)	68	650	11.1
1977-78	5,890	296 (5.0%)	10	2/	2/	225 (3.8%)	2/	641	10.9
1978-79	6,301	280 (4.4%)	16	122*		263 (4.2%)		681	10.8

1/ Excludes University of Puerto Rico.

2/ The data for 1977-78 differ from earlier years because of changes in racial/ethnic categories used for data collection. In 1977-78 there were 110 first-year students under a new category "Hispanic". Also, the former category of "Other minority" was eliminated.

* Hispanic including Puerto Ricans in U.S. schools.

NB Blacks = 11.6% of total U.S. population. Hispanics = 5.6% and Asians (all types) = 0.9%.

SOURCE: American Dental Association, Council on Dental Education. Minority Student Enrollment and Opportunities in U.S. Dental Schools, for 1971-72 and for 1972-73. Minority Report; Supplement of Annual Report on Dental Education 1973-74, and reports for subsequent academic years. Census of population Part I, U.S. Summary 1970. Bureau of the Census population profile of the United States: 1978.

J.L. Henry 9/21/79

All of these probably influenced what is happening. Nevertheless, the complexion of classes entering dentistry is changing in an unfavorable pattern for Blacks.

Especially distressing is that the decline in Blacks entering dentistry is masked in the overall total percentage of minority students seen in the column at the far right. This masking occurs because of the senesational increase in the number of entering Asians of all types from 112 in 1971 to 263 in 1978. This is a remarkable increase of 135 percent. The troubling factor is that Asians are not under-represented in the health professions or underserved. By and large, they are not economicaly disadvantaged. Harvard Medical School recognized this fact, and over the years has excluded counting Asians in meeting its affirmative action goals.

2.2. Medicine*

Application and acceptance rate of selected Black applicants to first-year classes in U.S. medical schools, 1973-74 through 1977-78 are presented below:

TABLE 2 **

First Year Class	Applicants		Acceptees	
	Number	Percent of All Applicants	Number	Percent
1973-74	2,227	5.5	977	43.9
1974-75	2,423	5.6	1,049	43.3
1975-76	2,288	5.4	945	41.3
1976-77	2,523	6.0	966	38.3
1977-78	2,487	6.1	966	38.3

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* Taken from the remarks of Mr. Albert Fisher, Executive Director, National Medical Association. September 21, 1979. CBC Health Manpower Task Force Workshop.

TABLE 3 **

Black enrollment in first-year classes in U.S. Medical Schools
(1971-1978)

Year	Number and Percent of Enrollment		Total First Year Enrollment
1971-72	882	7.1	12,361
1972-73	957	7.0	13,677
1973-74	1,027	7.3	14,154
1974-75	1,106	7.5	14,763
1975-76	1,036	6.8	15,295
1976-77	1,040	6.7	15,613
1977-78	1,085	6.7	16,136
1978-79	1,061	6.4	16,501

** Source: Medical School Admission Requirements 1980-81, United States and Canada, 30th Edition, Association of American Medical Colleges, One Dupont Circle, Washington, D.C.

2.3. Allied Health*

The practice of aggregating data to hide and distort true minority representation in allied health is common and typifies the quality of reporting minority data in allied health surveys. What we have is a two-tier system for the education and practice of allied health as follows:

1. Technician Category - these occupation clusters are predominantely minority oriented. The minimal education level usually is 2 or less years beginning after high school.

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* This analysis was taken from a paper by Mr. Harry Douglas Associate Dean College of Allied Health Sciences Howard University (Feb. 1980).

2. Technologist Category - these occupation clusters are usually lacking in significant minority representation. The education level for this level is 4 years and above and generally requires passing a national competency examination prior to practice.

The importance of systematic data collection cannot be over-emphasized if we are to accurately assess minority allied health manpower requirements and establish education priorities to meet these manpower needs. Finally, in order to obtain more persistent and reliable information, a uniform definition of allied health personnel for all levels is essentials.

While it is difficult to know the number of minority allied health professionals in the workforce, production data; namely, the number of minorities entering our education system is somewhat more reliable. For instance we know that minorities represent .01% of those entering Radiation Therapy Technology educational programs; 1.1% in Occupational Therapy; 1.8% in Physical Therapy; 0.4% in Allied Health Education, 0.8% in Physician Assistant. Additionally, an ERAH (Equal Representation in Allied Health) committee study revealed that 2.9% of all students enrolled in allied health education programs in 1976 were minorities and 2.1% of those enrolled in graduate allied health programs were minorities. Given these data we will soon experience a significant downward trend in the number of minority allied health practitioners as the production level is well below the corresponding percent of minority groups representation in terms of the general population.

TABLE 4

PERCENT ENROLLMENT OF FOUR MINORITIES IN 1975-76 COLLEGIATE AND HOSPITAL PROGRAMS, BY CENSUS DIVISION

CENSUS DIVISION	BLACK			NATIVE AMERICAN			ASIAN			HISPANIC			TOTAL MINORITY		
	Pop.	Coll.	Hosp.	Pop.	Coll.	Hosp.	Pop.	Coll.	Hosp.	Pop.	Coll.	Hosp.	Pop.	Coll.	Hosp.
1. New England	3.3	5.2	1.9	0.1	0.1	0.0	0.3	0.9	2.3	1.5	1.2	0.9	5.2	7.4	5.1
2. Middle Atlantic	10.6	10.8	9.2	0.1	0.2	0.2	0.4	1.1	1.4	5.3	2.5	2.6	16.5	14.6	13.4
3. East North Central	9.6	8.6	9.0	0.1	0.4	0.2	0.2	0.9	1.2	1.7	0.9	1.3	11.7	10.8	11.7
4. West North Central	4.3	4.7	4.4	0.6	2.0	0.7	0.2	0.8	0.8	0.8	0.6	1.1	5.9	8.1	7.0
5. South Atlantic	20.8	16.5	11.7	0.2	0.2	1.1	0.2	0.7	0.8	2.4	1.5	3.6	23.7	18.8	17.2
6. East South Central	20.1	12.9	13.7	0.1	0.4	0.0	0.1	0.7	0.8	0.2	0.3	0.6	20.5	15.0	15.1
7. West South Central	15.6	14.0	16.5	0.6	1.4	0.9	0.2	1.1	1.0	12.9	10.8	8.1	29.3	27.2	26.5
8. Mountain	2.2	3.4	2.9	2.8	3.1	7.9	0.5	1.3	1.0	12.1	6.7	8.6	17.5	14.6	20.5
9. Pacific	5.7	7.2	4.2	0.6	0.6	1.9	4.0	6.6	7.3	12.5	6.9	5.1	22.8	21.3	18.7
TOTAL	11.1	10.1	8.8	0.4	0.7	0.8	0.8	1.6	1.3	5.3	3.1	2.6	17.6	15.5	13.8

TABLE 5

TOTAL MINORITY ENROLLMENT DATA
ALLIED HEALTH

	Collegiate Programs		Hospital Programs	
	1975-76	1973-74	1975-76	1973-74
Total Enrollment	142,997	162,391	20,687	22,085
Percent Minority	15.9%	15.8%	13.8%	17.9%

(Percent Minorities in the population, according to the 1970 census in 17.6%)

2.4. Nursing*

It is generally recognized that minority groups are under represented in professional nursing as well as in other health and para-health professions. Currently, there are more than one million registered nurses in the United States today. The current status of practicing registered nurses indicates that of the nation's 976,000 active nurses, 45,000 are black (4.6%). These figures represent three different levels of educational preparation: 1) a four year program leading to a baccalaureate degree in 344 Collegiate schools of nursing in the country; 2) a three year program in 367 hospitals leading to a diploma; and 3) 647 associate degree program of two years in length usually based in a community college.

Seventy-seven percent (77%) of the total registered nurses are prepared below the baccalaureate level. Nurses prepared at the baccalaureate level constitute 18.5% and graduates holding master's degrees represents 4.3%. The total number of nurses with doctorate degrees is estimated at 1,500 or 0.2%. Of the total number of nurses holding masters or doctorate degrees, less than 5% are black and other racial minorities.

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* Taken from the paper of Mrs. Dorthy Powell, School of Health Related Professions and Natural Sciences, Norfolk State University. September 21, 1979. CBC Health Manpower Task Force Workshop.

About 2.5 percent of this population were black; 1.4 percent, Hispanic; 0.2 percent, American Indian; and 2.1 percent, Asian. About 1.5 percent did not report their racial/ethnic background.

An examination of the geographic distribution showed that half of the nurses with racial/ethnic background were located in the Pacific states (24.8 percent) and Middle Atlantic states (24.6 percent). The next largest numbers were located in the East North Central states (14.5 percent) and the South Atlantic states (13.9 percent).

The significance of this data reflects the lack of minority representation in nursing. With the competiveness of Physicians, it is virtually impossible for underserved and unserved communities to attract and retain doctors to meet the health needs of the residents. Consequently, the utilization of highly trained, educationally prepared nurses as major health care providers in high need communities can prove to be not only cost effective but vital in providing quality health care to consumers. It is a known fact that the majority of all racial-ethnic minority nurses, upon graduation, return to their communities and remain in the work force. These nurses and the nursing care they provide are the major determinants of how rapidly patients will recover from their illness and how well other health-care needs will be met.

2.5. Pharmacy*

There were 116,563 active practicing pharmacists in 1974 and 2,039 of these were black. This is 1.7% of the total. Black pharamcists practice primarily in independent and chain community pharmacies.

If we were to have an adequate number of black pharamcists in order to deliver a level of service available to non-black communities, we would need some 12,000 more black pharamcists.

* Taken from the paper of Dr. Rosalyn King, National Pharmaceutical Foundation. September 21, 1979. CBC Health Manpower Task Force Workshop.

TABLE 6

ENROLLMENT IN CONTINENTAL U.S. PHARMACY SCHOOLS

(Final Three Years)

	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	% Change
Total Students	13,068	14,122	14,753	15,097	15,326	16,476	18,445	20,830	22,688	13,836	23,465	23,273	23,078	+76
Women	15%	17%	18%	20%	22%	24%	25%	26%	29%	32%	36%	38%	41%	
Students	1,916	2,334	2,684	3,029	3,370	3,949	4,689	5,507	6,675	7,695	8,388	8,863	9,442	+380
American	DATA NOT AVAILABLE						9%	8.1%	7.6%	8.8%	8.9%	9.4%	9.8%	
Minorities*							1,662	1,684	1,727	2,090	2,089	2,192	2,263	+32

*Black, Hispanic, Asian, American Indian, and Other Minority Students.

Ten Years of Growth

Female and minority student enrollments have faired well over the past several years in pharmacy schools. During the past ten years, when enrollments in the Continental U.S. pharmacy schools increased 78 percent, female students increased a remarkable 363 percent. Since 1972, the first year data were collected on American Minority students, the number of these students increased 32 percent. Final three year enrollments at the 71 schools now total 23,273 students, of which 38 percent are women. Minority Enrollments now stand at 9.4 percent, and are comprised of 45% Blacks, 35% Asians, 16% Hispanics, 2% American Indians, and 2% Other Minority students.

Are there more being trained? In the past seven years minority enrollment in colleges of pharmacy has increased a mere 32%. In the last three years (1976-1978) the level of black student enrollment has remained around 4% of total enrollment which qualifies us for the title "under-represented minority" in the Colleges of Pharmacy. It is noteworthy that the percentage of black pharmacy students enrolled on the four predominantly Black Pharmacy Colleges -- TSU, Xavier, Florida A&M and Howard -- declined over those same three years from 51% to 48%. This says to me that black enrollment in the non-black schools has increased and our precious professional resource, the predominantly Black Colleges of Pharmacy, no longer trains a majority of our black pharamcists.

This trend of the decreasing number of black students and the decreasing number attending predominantly black colleges of Pharamcy is significant as the profession as a whole considers reports of the oversupply of pharmacists and expanding enrollment in the nations 67 non-black schools. There is talk in some segments of my profession about decreasing the oversupply by decreasing enrollments. But, you can see that we do not suffer from this oversupply disease!

The decreasing number of blacks in predominantly black schools in significant also as pharmacy moves to a more patient-oriented practice where there is need for sensitivity to our needs as black people.

2.6. Optometry*

According to the NOA data, the total representation of minority students within student bodies of the thirteen schools and colleges of optometry has increased from 29 (0.9% of the studenty body) in 1971 to a high of 138 (3.5%) in 1975, 140 (3.4%) in 1976, and 137 (3.3%) in 1979. (Table

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* Taken from the paper of Dr. Edwin Marshall, National Optometric Association. January, 1980.

TABLE 7

SUMMARY CHART: MINORITY OPTOMETRY STUDENT ENROLLMENT DATA

YEAR	FIRST YEAR ENROLLMENT	TOTAL NUMBER OF MINORITY STUDENTS ENROLLED					GRADUATES
		BLACK	HISPANIC	NATIVE AMERICAN	TOTAL	PER CENT OF STUDENT BODY	
1971	--	18	10	1	29	0.9%	--
1972	35	36	21	2	59	1.8%	6
1973	40	56	28	2	86	2.5%	7
1974	37	72	31	6	109	3.0%	3
1975	41	84	40	4	138	3.5%	13
1976	45	92	41	7	140	3.4%	22
1977	37	79	49	6	134	3.1%	25
1978	37	63	58	9	130	2.9%	32
1979	44	61	67	9	137	3.3%	18
TOTALS	316	561*	345*	46*	962*	--	126

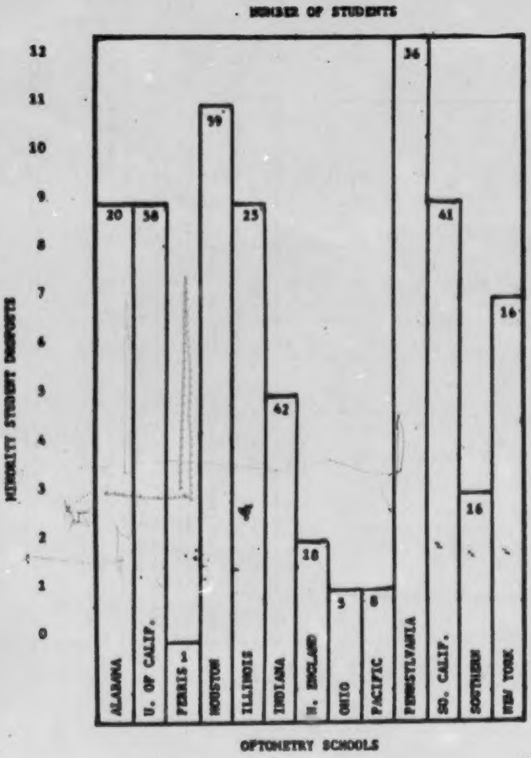
*Totals include duplicate counts of students enrolled in previous years

UNDUPLICATED NUMBER OF ENROLLED MINORITY STUDENTS

YEARS	BLACK		HISPANIC		NATIVE AMERICAN		TOTAL NUMBER OF MINORITY STUDENTS	ATTRITION	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE		#	%
1971 - 1980	114	82	100	27	21	1	345	75	21.7%

SOURCE OF DATA: National Optometric Association's Project To Increase Minority Optometric Manpower

TABLE 8
MINORITY STUDENT DROPOUTS
1971-1979



TOTAL # MINORITY STUDENTS 1972 -'79	
ALABAMA	20
U.C.	58
FERRIS	1
HOUSTON	39
ILLINOIS	25
INDIANA	42
NEW ENGLAND	18
OHIO	5
PACIFIC	8
PENNSYLVANIA	36
SO. CALIF.	41
SOUTHERN	16
N.Y.	16
	345

TOTAL DROPOUTS: 75

21.7 %

SOURCE OF DATA: National Optometric Association's Project To Increase Minority Optometric Manpower

TABLE 9

MINORITY OPTOMETRY STUDENT STATISTICS 1972 - 1979

OPTOMETRY	MINORITY GRADUATES							
SCHOOL	72	73	74	75	76	77	78	79
ALABAMA	0	0	0	0	0	0	1	3
UNIV. OF CAL.	2	2	0	4	5	3	5	3
FERRIS	0	0	0	0	0	0	0	0
HOUSTON	0	0	1	3	6	3	5	4
ILLINOIS	0	1	0	2	1	2	4	0
INDIANA	0	1	0	0	3	5	6	1
NEW ENGLAND	0	0	0	1	4	3	3	2
OHIO	0	0	0	1	0	0	1	0
PACIFIC	0	0	0	1	0	1	0	1
PENNSYLVANIA	2	1	0	0	0	3	1	0
SOUTHERN CAL.	0	2	1	0	1	3	2	3
SOUTHERN	0	0	1	1	2	1	1	0
ST. COL. N. Y.	0	0	0	0	0	1	2	1
TOTALS/YR.	6	7	3	13	22	25	32	18
TOTALS				126				

SOURCE OF DATA: National Optometric Association's Project To Increase Minority Optometric Manpower

The 1979 number of 137 minority students is composed of the following groupings (Table 7):

Black - 61 students (24 males and 37 females)
Hispanic - 67 students (51 males and 16 females)
Native American - 9 students (8 males and 1 female)

First-year minority enrollments accounted for 44 of the 137 minority students in 1979. (Table 7) For the earlier years, the number of first-year minority enrolled students were as follows: 1972 (35), 1973 (40), 1974 (37), 1975 (41), 1976 (45), 1977 (37), and 1978 (37).

The number of minority graduates from the schools and colleges of optometry have increased from 6 in 1972 to highs of 22 in 1976, 25 in 1977, 32 in 1978, and 18 in 1979. (Table 9) These new health professionals will help to improve the current disproportionate representation of minorities in optometry.

For the total years of the NOA Project, there have been 345 recruited minority students (Table 7).

Black - 196 students (114 males and 82 females)
Hispanic - 127 students (100 males and 27 females)
Native American - 22 students (21 males and 1 female)

Of the 345 recruited minority students, there were 75 "dropouts" for an attrition rate of 21.7% over the entire project period of 1972 to 1980. (Table 3).

A Summary Table on the Minority Optometry Student Enrollment Data is attached and presented to highlight the overall effect of the NOA Project in increasing the number of minority optometry students.

3. PAST AND CURRENT EFFORTS:
(94-484 INITIATIVES FOR INCREASING MINORITY STUDENT ENROLLMENT AND RETENTION IN HEALTH PROFESSIONS TRAINING)

One of the inferences that can be made from the above data is that past and current efforts, vis-a-vis PL 94-484, have been ineffective in addressing the issue of increasing minority student enrollment and retention in health professions training programs. In fact, at its outset (Sec. 2(a), PL 94-484 does not mention the issue in the statement of "Findings and Declaration of Policy."

The fact that only towards the end of PL 94-484, Secs. 787 and 798, does one find any substantial legislative initiatives to address minority student enrollment and retention. This seemingly puts into appropriate context the scope and level of past and current concerns for the issue. Section 787, "Educational Assistance to Individuals From Disadvantaged Backgrounds" contains the authority for what has become Health Career Opportunity Programs. Three basic shortcomings of this section have been (1) the failure of the authority to permit programs to sensitize and academically prepare minority students for health careers during the elementary and middle school years, (2) inadequate levels of appropriations to significantly increase either enrollment or retention rates of minority students in health professions training programs, and (3) failure to mandate or encourage more attention to the problems of minority student retention as opposed to enrollment.

Little else can be said about the current legislative initiatives, except that PL 94-484 has as the previously presented data suggest, been woefully ineffective in increasing minority student enrollment and retention.

4. COMMENTS AND RECOMMENDATIONS

(RELATIVE TO S.2375)

Part 1: Comments on S.2375 Proposals

The CBC Manpower Task Force finds several encouraging proposals in S.2375. To be more specific, the following sections deserve mention and in some instances questions and recommendations are provided.

Sec. 771 "National Priority Incentive Grants"

In replacing capitation as the basic element of support for the MODVOP areas, this section earns recognition because it defines and sets forth a target for minority student enrollment as one of the "national priorities." While laudatory, the incentives to be awarded institutions which have 15% or more full-time and full-time -equivalent student enrollment of underrepresented minority group seemingly places all emphasis of enrollment and none on retention. Could not such a system of rewards only serve to "Grease a set of revolving doors" in and out of MODVOP programs? Further, why is the figure of only 15% utilized as the target when under-represented minority peoples comprise more than 15% of the US population?

Sec. 773 "Enrollment Determinations"

Subsection (d) indicates that minority institutions will count each minority student three (3) times, hence the minimum amount of incentive grant to such institutions would become $2,250. This step deserves recognition as a measure whereby minority institutions can gain some credit for the staggering burdens which they have bore so well for years.

Sec. 787 "Educational Assistance to Individuals from Under-Represented Minority Groups and Disadvantaged Backgrounds"

This section is, of course, a restatement of Sec. 787 in PL 94-484 with several notable exceptions. First, eligible institutions in S. 2375 have been expanded to allow for establishing "secondary educational programs" to qualify for funding consideration. While this is an improvement over 94-484, this section continues to fail in not permitting programs to be established at the elementary and middle school levels.

The notion of establishing "joint programs" seems to suggest some interesting linkages. However, regulations which would subsequently be promulgated would become critical to insuring successful "joint programs."

Given the current authorities and appropriations in PL 94-484, i.e., $20,000,000, the rate of inflation (approximately 18-20%) and the scope of the problem of being underrepresented, the recommended amount of authority in S. 2375 ($30,000,000) does not seem adequate to truly change the statistics on minority student enrollment and retention in health professions training programs.

Sec. 788 (b) "Funds for National Priority Institutions"

The addition of the designation of "national priority institutions" and funds to assist those institutions in paying short- and long-term debts of such schools is a welcome inclusion in S. 2375. The CBC Manpower Task Force recommends a higher level of funding in establishing the authority for this initiative.

Sec. 792 "Conversion Project"

The CBC Health Manpower Task Force supports this section.

Title II Nurse Education Admendments (Sec. 810 National Priority Incentive Grants)

The Manpower Task Force has the same general comments for Sec. 810 as were provided above in reference to Sec. 771. Why only a 15% enrollment? Why not put greater emphasis on and therefore incentives into retention (as opposed to enrollment) of minority students in nursing programs? And why not more of a greater level funding authority for Sec. 810?

Sec. 820 "Special Project Grants and Contracts

The CBC Health Manpower Task Force supports paragraph (2), page 122 which calls for grants to increase nursing education opportunities for individuals from underrepresented minority groups or disadvantaged backgrounds," but again, questions the amount of funding authority which is proposed, given the statistical evidence available concerning the degree of being underrepresented among minority individuals.

Part 2: Recommendations

(1) National Advisory Council on Minority Education in the Health Professions

The CBC Health Manpower Task Force strongly recommends the formulation of a "National Advisory Council on Minority Education in the Health Professions." Given the scope of the problem, such a group seems to be a reasonable suggestion. This Council would have a similar scope of powers and duties as that of the "National Advisory Council on Health Personnel," but be specifically targeted to focus in on developing, implementing and monitoring progress toward increasing minority student enrollment and retention in health professions education. The chairperson of this advisory council should also serve on the National Advisory Council on Health (2) National Center for Minority Health and Minority Personnel.

Health Manpower Statistics

Such a center would be most helpful in charting the problem and progress which is made in solving it. Such a Center could be housed in a National Priority Institution.

The CBC Health Manpower Task Force appreciates this opportunity to share its comments and recommendations with the Subcommittee on Health and Scientific Research.

NATIONAL ASSOCIATION OF MEDICAL
MINORITY EDUCATORS, INC.

RECOMMENDATIONS FOR AMENDMENTS TO S.2375
SENATOR KENNEDY'S HEALTH MANPOWER BILL.

- 4/29/80

Comment: This bill is by far the most responsive to the NAMME legislative proposals. It addresses a number of our concerns adequately and should be supported on that basis. Since institutional incentives and student financial assistance stand at the heart of the problem of representation of minority students in health professions schools, our recommendations for amendments to the bill focus on these areas.

A) National Priority Incentive Grants

Proposed Amendments:

1) Increase base amount by 1.0 times for meeting minority enrollment criterion of 10% underrepresented minority students in first year class.

2) Scale other criteria to be 0.5 times (manpower shortage), 0.4 times (Family Practice), 0.3 times (Primary Care residencies), and 0.2 times (courses in priority areas).

3) Provide for a disincentive reduction in the base amount by 0.5 times if the total (all classes) underrepresented minority enrollment falls below 8.0 percent of total enrollment.

4) Provide for an incentive bonus increase of 0.25 times for schools with first year minority enrollment of 15% or more.

Discussion

As it currently stands, S.2375 does not identify the problem of the shortage of physicians from underrepresented racial minority groups with sufficient importance. If the schools and the advocate groups in the community are to be persuaded to put the best foot forward, this matter simply must have more priority than things like nutrition education and primary care residency programs. Weighting the priorities can achieve the desired purpose.

In addition to weighting priorities, we feel strongly that a 15 percent minority enrollment threshold is too high. In the last completed academic year (1978-79), 73 U.S. medical schools had first year minority enrollments of 10 percent or less. The aim of this legislation is to encourage the schools to improve, not simply to reward outstanding performance. In our view, the gap between 10 percent and 15 percent is simply too wide to be a true incentive. From this perspective, a reasonable alternative is lowering the threshold to 10 percent. A variation on this would be to make the threshold 10 percent in 1981, 12 percent in 1982 and move up to 15 percent in the fifth year.

We continue to be concerned that an incentive program based solely on first year enrollment does not address the output need. The highest attrition of minority students occurs in year one. It is essential that the structure of the incentive program be designed so as to encourage efforts to retain the minority students admitted in the first year. Since a separate incentive might find difficult sledding in the Congress, it seems more prudent to include a disincentive. We would expect that about half the U.S. medical schools would be impacted by the disincentive.

B) Exceptional Financial Need Scholarships

Proposed Amendments:

1) Provide for tuition plus $2,500

2) Maintain the authorization level at $18,000,000

Discussion

NAMME's position is that all students should take some responsibility for meeting the cost of their education. Even so, the EFN terms proposed in S.2375 would appear to be deficient in several regards. The limit of $5,000 does not provide sufficient leverage to give students applying to high tuition schools true career choice flexibility. The limit discriminates against private schools, the very schools which are now making the best efforts to enroll minority students. For example - in 1978-79, the first year enrollment of minority students in the six (6) private medical schools in New England averaged 11.97 percent. This is to be compared with an average of only 2.79 percent for the three (3) public medical schools in the region. Thus, it is in the national interest to insure that students who will attend private schools will be candidates for these awards.

The higher support levels will require that the authorization be maintained at its current levels or increased.

C) Health Professions Student Loan Program

Proposal: Extend Authority

This program provides much needed low cost loans. The availability of such loans helps to give minority and other disadvantaged students flexibility that they would not otherwise enjoy. If we are going to have minority representation in academic medicine as well as in the non primary care specialties, financial flexibility is a must. Students must believe that medical school is possible financially.

It is noteworthy that more than 1200 students who were accepted to medical school for entry in 1979-80, opted not to matriculate. This is as compared with only 391 such declinations in 1978-79. No comprehensive study of this disturbing circumstance has been done, but anecdotal evidence suggests that cost of medical education was a critical factor. We can ill afford the exacerbation of this condition which will occur if options for financial aid are closed more.

# # #

Juel Hodge-Jones
Legislative Committee Chairman

Levi C. Adams
President

ELMER C. BAUM, D.O., CHAIRMAN
COUNCIL ON FEDERAL HEALTH PROGRAMS

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American Osteopathic Association

March 10, 1980

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health and
Scientific Research
Committee on Labor and Human Resources
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

On behalf of the American Osteopathic Association, I am pleased to extend to the Subcommittee on Health our appreciation for the exceptional level of cooperation and receptiveness which we have experienced during the initial phases of the development of legislation to renew the Health Professions Educational Assistance Act.

In testimony before the Subcommittee this morning, the American Association of Colleges of Osteopathic Medicine will outline their position with regard to this vital legislation. The American Osteopathic Association concurs in the statement which will be presented to you by Dr. Moore. We trust that the Committee will insure that any Manpower bill that it reports will appropriately reinforce the Osteopathic training model which is producing a significant number of primary care physicians.

Realizing that reauthorization of this Act is vitally important in assuring the continuation of quality medical care in this country and in improving opportunities for those choosing to pursue a career in the health professions, we wish to re-emphasize our continued willingness to assist in any way we can.

Sincerely,

Elmer C. Baum D.O.

Elmer C. Baum, D.O.
Chairman, Council on Federal
Health Programs

ECB/dmk

cc: Senators Pell, Nelson, Williams, Cranston, Metzenbaum,
Schweiker, Javits, Hatch, Humphrey

Record Statement of
The American Dental Association
on
Health Manpower Legislation
Before the
Subcommittee on Health and Scientific Research
Committee on Labor and Human Resources
United States Senate

March 20, 1980

Mr. Chairman and Members of the Subcommittee:

The American Dental Association has prepared a lengthy series of recommendations on the health manpower legislative proposals which are currently pending in Congress. These comments are contained in the body of this statement and in the supplementary documents which are appended. Before addressing the specifics of these bills, the Association wishes to first discuss several issues of particular importance to dentistry which it believes should be considered in the development of any new health manpower law.

-- The dental education system rests upon an extremely fragile economic base. Ten years ago the average, annual cost to train a dental student amounted to about $10,000. Today the yearly educational cost is estimated to exceed $21,000 - one of the highest of the health professions. Each source of public and private revenue which our schools are able to generate represents a critical element within this financial matrix. For most dental schools, a viable program of federal assistance is not simply desirable, it is essential. Schools of dentistry are currently receiving over $21 million in annual institutional (capitation) grants. These funds sustain the basic instructional activities of our educational system with an average of more than 56 percent of this support utilized for faculty and staff salaries. At some schools this figure exceeds 80 percent.

-- The Association is concerned that in the absence of adequate federal assistance, a large number of dental schools will be forced to raise tuition to unacceptably high levels. The consequence of this action is already evident in the precipitous decline in dental school applicants which has occurred since 1974. Between the academic years 1973-74 and 1979-80 the average tuition rate at all dental schools increased by 126 percent. During this same period the number of individuals applying to dental school fell by 26 percent. (See attached analysis)

-- The relationship between increasing student indebtedness and future practice patterns must also be examined. Data obtained by the American Association of Dental Schools in separate surveys of 1978 and 1979 indicates that an increasing number of graduating seniors are deferring the establishment of self-employed private practices and are instead seeking to associate with existing practices or obtain salaried positions in the military, Veterans Administration or U.S. Public Health Service. This concentration of dental resources produces an excess capacity in certain segments of the delivery system while aggravating the problems of geographic maldistribution in areas without adequate access to dental care. We also foresee the possibility that increased indebtedness will ultimately translate into higher dental fees and the establishment of practices in economically attractive areas, thus contributing to the twin problems of rising health care costs and geographic maldistribution of health personnel.

-- We believe it is also necessary to recognize the link which exists between a financially sound dental education system and improved dental care delivery. This Subcommittee is aware of the large scale enrollment increases which have been achieved since the inception of direct federal support to the health professions in 1963. It is frequently overlooked, however, that the greatly expanded dental education system is also a significantly improved system. The fiscal stability and financial incentives which previously were assured under the health manpower statutes have enabled schools of dentistry to improve faculty-student ratios, replace outmoded teaching facilities and, of particular importance, launch new programs emphasizing:

- dental disease prevention
- increased productivity
- primary care
- quality assurance and peer review, and
- the dental care needs of underserved populations, the elderly, handicapped and other special groups.

These programs are, in the opinion of the American Dental Association, both effective and relevant to the national issues which have been identified by Congress and the Executive. Similarly the ability of our dental schools to continue to respond to these objectives is, we believe, unquestionably tied to an adequate and predictable level of direct federal assistance.

-- If it is determined that such support is to be accompanied by prudent requirements, we must insist that these conditions be appropriate to dentistry and compatible with the resources of the dental schools. There has been a perception in the past that problems which may exist in one delivery system are present in all disciplines. For dentistry, this has occasionally led to the enactment of requirements for federal grants which have been inappropriate and potentially counterproductive. Recognition that dentistry and dental education is separate and unique from the other health professions is therefore a necessary beginning in the development of any new manpower law. A principal element which should accord an independent status for dentistry is the national resource function of the dental schools. In contrast to medical education with 125 schools, dentistry has only 60 degree granting institutions. More importantly, 17 States do not have a dental school. Consideration should also be given to the high cost to train a dental student, the absence of any significant private or philanthropic assistance for dental education, limited federal and other third party reimbursements for dental school clinical services and, the physical constraints which are inherently present in dental instructional facilities.

-- Careful consideration should be given to the period of authorization for a new health manpower law. Over the past 18 years, each successive renewal of the manpower statutes has produced new "national priorities", revised levels of federal assistance and, in some instances, an abrupt termination of funding for on-going programs. This experience prompts the Association to recommend that Congress evaluate the feasibility of a five year authorization for these programs of support. Continuity and predictability of revenues is as important to dental education as it is for any other large and complex enterprise. If this concept is carried through in new legislation, a five year authority would provide dental schools with an initial 12 months in which to evaluate and qualify for assistance, and four years in which they can assume a measure of stability in the requirements for such support.

The remainder of the Association's statement will address, within the context of selected programs, the health manpower bills which have been introduced in Congress to date.

Institutional Support

The legislation to be introduced on behalf of the Administration and the measure (S.2144) sponsored by Senator Richard Schweiker, propose to terminate the authority for capitation grants. Although the ADA believes that the capitation program, as presently structured, must be substantially modified, it nevertheless remains committed to the concept of federal institutional support to the health professions schools. The Administration contends that earlier health manpower problems such as a shortage of health personnel have largely been resolved and that others, including a geographic maldistribution of practitioners, can best be addressed through the National Health Service Corps. As a consequence, it is argued, the capitation grant program has outlived its utility and should be eliminated.

The ADA concurs that further mandatory enrollment increases are unnecessary. There is every indication that the dental care delivery system has sufficient flexibility to meet present and projected demand for services. As we have attempted to demonstrate, however, any abrupt decision to withdraw federal institutional support would have a profound, negative effect on efforts to improve access to care.

The proposed elimination of institutional assistance in S.2144 is partially off-set by an expanded program of highly targeted Special Project grants. Our objection to this approach does not stem from the goals which are expressed in these projects, but rather from the inability of this funding mechanism to ensure an adequate and predictable level of federal support. As noted earlier, dental schools are currently receiving over $21 million in annual capitation grants. Because a majority of the schools would be unable to generate replacement funds, a benchmark by which we must evaluate any alternative grant program is the extent to which it will provide a level of assistance that is at least equal to that presently received by schools of dentistry. The Special Project Grant program as proposed in S.2144 fails to meet this standard.

As we understand the provisions of S.2144 (Part C), it will be necessary for dental and other health professions schools and entities to compete for a limited amount of Special Project Grant funds allocated among a number of discreet activities. The immediate dilemma which would result from this concept is the uncertainty as to the amount, if any, which an applicant institution would actually receive on a year to year basis. This problem is further compounded by the fact that the total sums to be authorized and available under both Special and Supplemental Project Grants are considerably below the levels of assistance currently provided under P.L. 94-484. Of the ten categories of project grants for which dental schools would be eligible to compete, two are presently funded under the existing Special Project Grant authorities and cannot, therefore, be considered as a partial replacement for capitation grants. A third, Remote Site Training, is a requirement of capitation grants and 38 dental schools have in fact exercised this option. A total of over $15 million is currently awarded to these institutions for the support of remote site training whereas only $5.5 million is authorized in fiscal 1981 under S.2144 for this purpose for all health professions schools. The remaining categories (7) of Project grant assistance for which dental schools may apply, in competition with medical and other professional and allied health schools, have a combined fiscal year authorization of less than $40 million - again underscoring the inadequacy of Special Project grants as a meaningful replacement for institutional support.

Section 730 of the bill would authorize a 20 percent increase in the level of a school's Special Project grant(s) if certain conditions are met. There are three drawbacks to this approach. An initial problem occurs because the sums which an institution could receive through these "supplemental" awards are determined by applying a factor of one-fifth to the amount of a school's Special Project award(s) rather than on the basis of what it will cost to meet the requirements outlined in section 731. Secondly, the uncertainties of support which are associated with Special Project grants, described earlier, are carried forward in the funding mechanism for the proposed supplemental awards. In other words, a school of dentistry would agree, presumably at the time of application submission, to meet the conditions of Section 731 in return for an additional award to be calculated by applying 20 percent to a then unknown level of Special Project grant assistance. And, finally, given the limited amount of funds to be authorized for Special Project grants, many schools may simply conclude that an increase of 20 percent does not justify the added expense which would be incurred in meeting the assurances called for in Section 731.

The measure, S.2375, sponsored by Senator Edward Kennedy would replace capitation assistance with a new National Priority Incentive Grant Program. As we understand the proposal, dental and other health professions schools would be entitled to an annual base level of support (calculated) initially at $500 per student) with additional sums to be added in return for meeting specified objectives. Conversely, the bill provides for decreases in the amount of such support if certain negative factors are evidenced in a school's teaching program. There is a degree of merit in this approach, both in the fiscal stability which would result from annual entitlement grants and in the flexibility that allows dental schools to respond to a series of national goals in return for additional financial assistance. Unfortunately a number of the incentives outlined in Section 772(e)(21) of the bill are either unrealistic or inappropriate for the dental education system.

Two of the provisions of that section, establishing a requirement for a 15 and 40 percent first-year enrollment, respectively, of minority and female students are simply not achievable for most dental schools. Inadequate programs of student aid, increasing tuition and other educational expenses, and a declining applicant pool are largely responsible for this situation. Even if these barriers were to be immediately addressed in a new manpower law - as the Association is urging - the lag time before an appreciable number of minority and female applicants seek admission to dental schools is still several years away. A more positive approach to this issue would be an incentive to encourage and assist dental schools to establish programs which are designed to identify, recruit and consult minorities and females to pursue a career in dentistry. A third incentive to be met (772(e)(2)(c)), regarding primary care and public health, is not only unnecessary for dentistry, it is also potentially counterproductive. Because the dental care delivery system has, until recently, been allowed to function with a minimum of federal intervention, the profession has achieved a very positive ratio of general practitioners to specialists. In this instance a 9 to 1 distribution. To arbitrarily establish this ratio as a national standard for all dental schools fails, initially, to recognize that an overwhelming majority of the advanced training in general dentistry and public health occurs in hospitals and other settings which are not affiliated with dental schools. More importantly, this requirement works to the disadvantage of those developing schools which will serve areas of the Nation with an unusually small percentage of dental specialists. To cite an example, one new dental school is located in a State in which the total supply of active specialists numbers less than 70. What purpose then would be served by encouraging such institutions to emphasize primary care when there may be a demonstrated need for dentists who have received advanced training in specialized skills. The Association believes this issue can more properly be addressed within the provisions of Section 786(b) of the current law which provides grants and other assistance for dental general practice residency training programs.

A fourth incentive of S.2375 calls for (A) a first-year dental school enrollment in which 10 percent of the students are from health manpower shortage areas designated under Section 332 of the PHS Act, and (B) the establishment of off-site training programs as required in the present law. With respect to the first condition, it should be recognized that only 861 areas have been designated under Section 332 as dentally underserved. Thus the goal of 10 percent first year enrollment is unrealistically high. At the same time however there are presently 11 States without a dental school. Historically these States have relied upon private dental schools to provide training opportunities for their residents. As these private institutions have been forced to obtain State assistance in one form or another, the percentage of out-of-state enrollment has declined significantly. The extent of this shift in admissions raises a serious concern as to the future availability of student places for residents of states without dental education programs. In view of these factors we would recommend that the proposed requirement be lowered to 5 percent and applied to a combined total of students from both underserved areas (Section 332) and states without a dental school.

Because of the cost of establishing and maintaining an off-site training program, the Association believes that this second condition should be separated from paragraph (D) and made an independent incentive.

The ADA endorses the incentive outlined in paragraph E. We would also recommend that additional incentives be added to Section 772(e)(2) which provide experiences in the provision of care to special population groups, i.e. handicapped, residents of nursing homes, and institutionalized patients. To ensure an equitable distribution of the limited funds which are to be authorized (Section 774(c)) for the proposed National Priority Incentive Grant program, the Association further recommends that participating dental schools be limited to a maximum of five incentives per institution.

Section 772(e)(3) of the bill proposes two disincentives which, if applied, would reduce the sums available to a dental school under this program. The Association recognizes that one of the penalty provisions, relating to allowable tuition increases, is a requirement of current law. We are not aware of any situation in which this limitation has adversely affected a dental school. For many of our private schools, however, a decline in federal funding of institutional support grants would leave no alternative to an increase in tuition levels. The recent record of appropriations for health manpower programs provides ample justification for this concern. We would also note that for some institutions, decisions regarding tuition are not a function of the individual professional schools but of the university administration or a higher authority (as in the case of certain state education systems). The American Dental Association certainly endorses efforts to restrain tuition increases. In our opinion, however, this should more appropriately occur at a level where the most accurate assessment can be made of a dental school's finances. Accordingly we recommend the elimination of this provision of S.2375.

The Association strongly supports the intent of the second disincentive relating to enrollment increases for schools of dentistry.

The final bill on which the Association will comment, as it relates to institutional support, is H.R. 6802. With the exception of certain modifications, this measure is for the most part a three year extension of the current authorities. Capitation grants for dental schools would, as we understand the bill, be continued with the same unnecessary and burdensome requirements that exist today. We cannot accept this proposal and therefore urge its rejection.

Student Assistance

The most recent information available to the Association indicates that a sizeable majority of the more than 22,000 dental students require financial assistance to complete their education. It is reasonable to assume that both the absolute number of students seeking aid, as well as the level of assistance required, will grow in proportion to the additional increases in tuition which can be expected to occur in the next few years. As noted earlier, the average tuition increase at all dental schools has exceeded 126 percent over the past five years. The total annual cost to the dental student (tuition, fees, instruments and living) presently averages about $12,000. In the face of this financial need, dental students must rely upon a confusing, inadequate and at times conflicting array of federal assistance programs.

In the opinion of the ADA, a comprehensive and fiscally viable program of health professions student aid must be accorded priority consideration in any renewal of the health manpower law. Such a program should be responsive to the needs of the participant while in school rather than on a perception of high income in later professional life. Basic elements of this authority should include:

- An extension of the Health Professions Student Loan program with an increased federal capitalization. Direct student loans which are awarded under this authority should be targeted to "financially needy" students with an overall ceiling on allowable student indebtedness;
- A new federally insured/guaranteed loan authority for health professions students as a replacement for the existing HEAL program. Interest subsidies should be available, initially to the borrower while in training, and subsequently to the lender, in order to reduce the total cost of the loan while still generating participation from the private capital lending market; and
- A two year program of scholarships for minority and disadvantaged students.

The position of the Administration on this issue is one in which students are expected to assume an increasingly higher percentage of their educational costs. Little if any consideration has apparently been given to the effect of this policy on the applicant pool or the practice characteristics of future graduates. Federally insured loans are offered by the Administration as the principal mechanism for health professions students to finance their education. The ADA believes that this program (HEAL), as presently authorized, is so completely inadequate and unacceptable that it should not be considered as a viable student assistance program - even as a supplemental source of aid. To propose, as we understand the Administration has, that the present 13 percent interest ceiling be lifted on insured loans is, to say the least, astounding. The effect of an 18 to 20 percent interest rate on the health professions educational system should be quickly apparent.

The Administration has indicated that National Health Service Corps scholarships will provide a measure of financial assistance for dental and other health professions students. We believe there is a fundamental contradiction in the Administration's approach to this issue. Corps scholarships are advocated at one level of HEW as a mechanism to address the problem of access to care. This contrasts with the position of another arm of the Department which suggests that these scholarships represent a student assistance program. We respectfully submit that it cannot serve both objectives. The dilemma which results from this duality is readily apparent when the following statistics are considered. It is estimated that the 1979-80 entering class of the 60 dental schools is in excess of 6,400 students, with a total dental school enrollment of approximately 22,000. According to the Department, approximately 185 new NHSC scholarships are available for dentistry this academic year. As should be obvious, this number of dental corps scholarships is woefully inadequate if the NHSC program is viewed as a student aid mechanism. Conversely, if the number of Corps scholarships allocated for dentistry were made equal to the demonstrated financial needs of the entire dental student body, the number of graduates obligated to serve in an underserved area would be far in excess of the requirements of the National Health

Service Corps program. In summary, the Association strongly recommends that the Department administer the National Health Service Corps as it was originally intended; namely as a temporary alternative until more permanent solutions can be found to remedy the problems of access to care. The actual number of Corps scholarships which are provided to dentistry should, in turn, reflect the present and projected need for dental personnel in documented shortage areas. Student aid should more properly be addressed within the context of direct loans, an improved guaranteed loan program, loan repayments, and scholarships for minority and other disadvantaged students.

Two measures dealing with health professions student assistance have been introduced by Senator Richard Schweiker, S.1642 and S.2144. The ADA would caution against a reliance upon a single mechanism for student assistance as is proposed in S.2144. Although the bill has considerable merit in providing for insured student loans with in-training interest subsidy and loan forgiveness for shortage area service, the advantage of S.1642 is the decision to improve the existing, complimentary authorities for direct student loans, HEAL, and Exceptional Financial Need Scholarships. Each of these programs is designed to meet the particular needs of different segments of our student population. The fact that certain authorities, such as HEAL, have been found lacking can be remedied through interest subsidies and other improvements which are contained in S.1642. Direct loans (HPSLS) have been an effective student aid approach since the inception of federal health manpower support in 1963. Within a few years the individual school loan funds have the potential to become self-sustaining. Federal capital contributions would then become unnecessary, thus realizing a major cost saving to the taxpayer. Exceptional Financial Need Scholarships should also be continued and indeed made available to needy students for at least two years. For students from disadvantaged backgrounds, the expense of a dental education and subsequent establishment of a practice requires federal support that is beyond direct or insured loans. Scholarship assistance in the form presently authorized is, in our opinion, the most equitable and effective mechanism.

The measure, S.2375, proposes an ambitious program of "need-based, campus-oriented loans" for the health professions. We believe there are several major defects in this concept. An unacceptably high cost in the initial years of operation will, in our opinion, have the unintended effect of placing severe financial pressure on other health manpower programs. The Association also questions the rationale for adding a service commitment to this loan program in view of the proposed extension and expansion of National Health Service Corps Scholarships, as well as the continuation in S.2375 of the loan repayment for shortage area service program. These latter two authorities already provide an ample pool of graduates for service in underserved communities. The creation of yet a third source of obligated students will have the unavoidable consequence of placing large numbers of graduates in areas which have at best a marginal need for additional dental practitioners.

H.R. 6802 provides, with some modification, an extension of the student aid programs presently authorized under P.L. 94-484. As the

Association indicated earlier, there is considerable merit in expanding and improving the current assistance programs. In this case, we recommend that the direct (HPSL) loan authority serve as the principal mechanism for financial support. This would require a substantial increase in the proposed levels of expenditures over that contained in Section 206 of the bill. With respect to federally insured loans (HEAL), there is an urgent need to enact an interest subsidy provision if this program is to be of any value. We do not regard the proposed amendment in H.R. 6802, deferring interest payments while in training, as a meaningful improvement. Indeed this change may only serve to compound the problem of indebtedness following graduation. Two changes are required in Section 207 extending the authority for Exceptional Financial Need Scholarships. Under current law, these scholarships are limited to first-year students only. One year of assistance for students from disadvantaged backgrounds will accomplish little to increase minority representation in the health profession. The Association therefore recommends that a minimum of two years of support be authorized for scholarship recipients. Similarly, the proposed authorization levels in this section must be raised to more realistic levels if the program is to have any significant impact.

Dental Project Grants

The existing law, as well as the major health manpower bills which have been introduced, provide grants and contract support for a number of dental and dentally related demonstration type projects. These programs include interdisciplinary training, TEAM, expanded function dental auxiliary training, and others. Because of the fiscal constraints that will undoubtedly influence decisions regarding a new health manpower law, the Association recommends that the authority for these activities be terminated with the funds redirected to support an improved program of institutional support to the schools. This will, initially, ensure a more equitable distribution of federal assistance. Dental schools which elect to participate in a new institutional support program would then have the option to continue or phase-out these demonstration projects as circumstances dictate.

Dental General Practice Residencies

Section 786 of the Public Health Service Act requires that not less than 10 percent of the amounts appropriated in each fiscal year for grants to Family Medicine and General Practice Dentistry shall be made available for dental residency training. These programs have been particularly effective in providing the future general practitioner with the skills and experiences necessary for the provision of comprehensive, primary dental care. For reasons which we fail to understand, the Administration is once again requesting the elimination of funds for this important program. Such action is particularly surprising in view of the Administration's stated emphasis on the need to increase the number of primary care practitioners. The Association accordingly recommends a continuation of support for Section 786.

National Health Service Corps

The American Dental Association has a long standing record of support for programs to improve access to dental care for underserved and other special population groups. Almost thirty years ago the Association adopted policy urging its constituent societies to survey the dental needs of these populations, develop demonstration projects which address these needs, and implement broad-based efforts to reduce or eliminate barriers to comprehensive dental care.

More recently, the 1979 ADA House of Delegates approved a landmark report titled, "Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care". The report contains a series of 32 significant recommendations which, we believe, can serve as a national strategy for bringing all citizens into the mainstream of the dental care delivery system. Of particular importance is the decision to focus existing resources of the Association on five population segments: (1) the poor and working poor, (2) the elderly, (3) the underserved and remote-area residents, (4) the handicapped, institutionalized and homebound, and (5) the worker without dental prepayment insurance.

Fundamental to the thrust of the "access" program is the concept that improved oral health of our citizens requires a shared responsibility to be borne cooperatively by the dental profession, government at all levels, the private sector and the individual. In recognition of an appropriate federal role in achieving these objectives, the Association is presently endorsing separate legislation to provide comprehensive dental care for the elderly under Medicare Part B, (H.R. 1015) and mandate dental services under Medicaid for children of low income families, (H.R. 4962).

This recognition of a federal role does not, however, include the provision of dental services in those areas where dental care is available from the private sector. Nor does it extend to the support of those federal health care delivery programs whose effectiveness can no longer be demonstrated. It is for this reason that the Association must express a strong objection to the projected size, cost and current program philosophy of the National Health Service Corps.

Recent statements by HEW officials indicate that the field strength of the Corps in 1990 will exceed 9,000 personnel. When this figure is applied to the Department's current cost estimate of $110,000 to establish and maintain a medical or dental Corps practice for the first year, the budget of the NHSC within 10 years will approach $1 billion. We do not believe that Congress or the American public is prepared to undertake such a costly venture.

The Association is also concerned that the Department has unilaterally changed the thrust of the Corps to such a degree that it bears little resemblance to the intent of the original law. We are particularly disturbed over the apparent shift in emphasis away from the solo practice delivery model to the promotion of a permanent federal presence in the form of fixed-site clinics. Department officials now indicate that a majority (80%) of future Corps dental placements will be in "integrated delivery systems", i.e. Community Health Centers and other fixed-sites. In addition to penalizing those underserved communities which do not have these health centers, this approach virtually precludes the evolution of Corps sites into self-sustaining private practices.

The validity of the private practice model for dentistry is clearly demonstrated by the experiences in Washington and other states included within HEW Region 10. Of the eight National Health Service Corps dental sites that have been established since 1972 in private practice settings, seven have converted to successful independent practices, and the eighth Corps site is expected to follow this pattern. Despite this impressive record, Region 10 is under the same pressure as all other HEW Regional Offices to give priority in dental Corps assignments to fixed-site centers.

Another negative aspect of the current operation of the National Health Service Corps can be seen in the low percentage of dental placements in underserved areas which are designated as having the greatest need (priority 01 and 02). The Association understands that almost 50 percent of all Corps dental assignments have to date been in areas with an 03 and 04 identification, the lowest quartile. This results in part from the emphasis on fixed-site placements and in the latitude allowed for site selection by NHSC personnel. It is also a reflection of the failure of Corps officials to work cooperatively with, and take into account the efforts of, local public and private groups in programs to improve access to care. By placing dentists in areas of marginal need, the Corps has placed itself in direct and unwarranted competition with private practitioners. These situations could be avoided if the local dental societies are given a more meaningful role in the designation of underserved areas and the possible placement of Corps personnel in these areas. At a minimum, there must be a greater opportunity for the local society to comment on proposed Corps assignments to their communities, and if appropriate and feasible, to offer less costly and more lasting alternatives to the NHSC. The Association strongly urges the adoption of amendments which allow a period of not less than 90 days for health professional societies to submit their comments during the designation and assignment process.

In summary, the ADA believes that the National Health Service Corps was enacted as an interim measure; one that would serve as a catalyst for the development of private practices. Unfortunately this concept has largely been abandoned as the Department has moved to create what appears to be a permanent federal health care delivery system.

Senate bill S.2144 proposes to shift the focus of service programs from the federal to the state level. This approach, at least in concept, deserves consideration. Present federal policy in the health care sector is toward local responsibility through a network of health systems agencies established under Public Law 93-641 and continued under P.L. 96-79. The basic assumption behind this thrust is that local planning organizations are in better positions than federal agencies at either a regional or national level to understand differing needs and patterns of care of local populations. A logical extension of this assumption is that state health departments are in a better position than the Department of Health and Human Services to evaluate need for publicly subsidized health professionals.

A second consideration for the establishment of state-operated service programs (in lieu of the NHSC) involves allocation of intra-state resources. Under the current program, professionals are assigned to shortage areas without regard to place of training. Since a majority of NHSC Scholarship recipients are graduates of northern schools while a majority of shortage areas are located in the south, this means that most

Corps professionals are trained in one state for four or more years and subsequently assigned to NHSC sites in another state. Where professional schools are subsidized in part by state revenues, this has the effect of unfairly reallocating resources from one state to another and acts as a disincentive to states to support training programs. In a program operated by the states, each state government could determine need for publicly subsidized professionals and could then invest in training and placement accordingly. This would have the further advantage that professionals drawn from and trained in a given state may be more likely to remain there and to effect long-range solutions to health manpower shortages.

A third advantage to a state-operated program involves licensing of professionals serving under public auspices. A continuing problem encountered with the National Health Service Corps has been the assignment of Corps professionals to sites in states in which they do not hold an appropriate license to practice. This occurs when professionals are matched to sites in states other than those in which they have previously trained or practiced. Corps members are required to take the required licensure examination at the earliest possible time, but this is often a significant period of time after the placement and in cases in which the professional fails to pass the exam, allowance is made for retaking it at the next opportunity. The result of this situation is that in many cases NHSC professionals provide care for extended periods of time without holding the appropriate license. If individual states trained professionals for service in those same states, it would be possible to provide for licensure arrangements based upon knowledge of the professional's educational background and to otherwise ensure that publicly supported professionals meet the requirements for practice in each individual state. This would both facilitate relationships with private professionals and inspire confidence among potential patients regarding the competence of the public service professionals.

There are two major deficiencies in this program as proposed in S.2144. The process of shortage area designation would remain, for reasons unspecified, a federal function. If the scholarship program is to be largely a state responsibility, then it should follow that the designation process, which ultimately determines the need for graduates with service commitments, should be a state function. There is a striking absence of information, in S.2144, regarding the placement process and operational requirements of the program. Given the wide range of problems encountered in the current federal program, it seems necessary to us that detailed legislative guidance be provided for any new initiative in this area. It is our experience that reliance on regulatory interpretation should be minimal for direct service programs.

The Association has developed a detailed set of recommendations on the existing NHSC program. We believe these suggested revisions (which are appended to this statement) can serve as the basis for statutory improvements to the current law and, where appropriate, as the framework for alternative approaches such as proposed in S.2144.

This concludes the Association's statement.

THE INFLUENCE OF CAPITATION AND TUITION ON THE DECLINE IN DENTAL SCHOOL APPLICANTS

Since 1974 there has been a significant decrease in applicants to dental school. Using data collected by the American Association of Dental School's Applicant Service, (AADSAS) the number of applicants to 44 of the 60 dental schools in the United States which use this service is shown in Table 1. An examination of this data

TABLE 1

Number of Applicants to Dental Schools Using AADSAS

Year	1975	1976	1977	1978
No. of Applicants	13,202	12,626	10,658	9,690
Percent of Decrease		4.4%	15.6%	9.1%

indicates that the number of applicants dropped from 13,201 in 1975 to 9,690 in 1978, a decrease of 26.0% over the three year period. Figures for this fall's entering class are not yet in, but there is every indication to believe this trend has continued.

Other significant trends also emerge in examining the socio-economic variables contained in the AADSAS data. Table 2 provides the distribution by father's education for applicants in the 1975 to 1978 AADSAS cycles. An examination of the data indicates that for the 1978 cycle the decrease in applicants whose fathers had a college education was significantly less than expected while the decrease

TABLE 2

Father's Education

Education	1975	1976	1977	1978	Frequency Expected	x^2
Graduate Degree	3,000	3,029	2,533	2,646	2,213	82.6
Some Graduate School	562	545	436	410	416	0.1
College Graduates	2,066	2,136	1,963	1,667	1,528	12.6
Some College	2,250	2,168	1,955	1,556	1,664	7.0
High School Grad./Tech.	3,477	3,229	2,263	2,326	2,571	23.3
Some High School	1,042	872	713	628	771	26.5
Elementary Education	614	580	544	393	454	8.2
Unknown	91	67	39	61	67	0.1
TOTAL	13,102	12,626	10,446	9,690		
Missing*			239			

*Information was either miscoded or missing from students' applications.

was significantly greater than expected for those whose fathers had only a high school or less than high school education.

Table 3 presents a distribution of the amount of financial support expected for dental education from the applicant's parents. For the 1978 cycle the data indicates that for categories under $3,000 of aid, the decrease was substantially more than expected whereas in categories over $3,000 it was substantially less than expected. Both of these tables taken together indicate that the decline in applicants which has taken place during the last five years has been significantly greater for applicants coming from socio-economic lower middle income classes.

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TABLE 3

Amount of Financial Support Expected for
Dental Education From Parents/Relatives

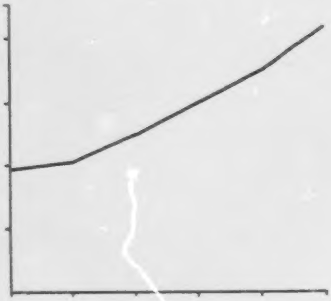
Dollars Amount	1975	1976	1977	1978	Frequency Expected	x^2
0- 999	4,417	3,866	1,477	1,960	3,270	524.8
1,000-1,999	2,302	1,995	2,193	1,199	1,704	149.6
2,000-2,999	2,008	1,805	1,291	1,257	1,486	35.3
3,000-3,999	1,341	1,355	1,481	935	993	3.4
4,000-4,999	898	882	1,213	754	665	10.1
5,000-5,999	854	975	848	936	632	146.2
6,000-6,999	384	429	1,035	474	284	127.1
7,000-7,999	196	250	521	326	145	225.9
8,000-8,999	160	225	304	312	119	313.0
Above 9,000	528	841	315	1,537	391	3,358.8
Total	13,088	12,523	10,678	9,690		
Missing*	14	3	7			

*Information was either miscoded or missing from student's application.

Table 4 presents a graft of the average annual tuition for the first year of dental school from 1974 to 1979 (1). In the last five years

TABLE 4

Average Annual First Year Dental School Tuition

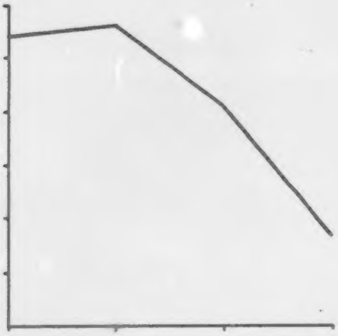


from 1974 to 1979 the average tuition has increased 125% from $1,908 to $4,292. From an inspection of the curve presented in the table, the increase has become greater each year.

Table 5 presents data for the average amount of federal capitation per undergraduate dental student reported to the American Dental Association by all fully operational dental schools for the fiscal years ending from 1975 to 1978 (2). An inspection of the table indicates that for the last three years of this period, the amount of capitation per student has dropped 42% from $1,914 per student in FYE 1976 to $1,114 per student in FYE 1978.

TABLE 5

Amount of Federal Capitation
per Predoctoral Dental Student



CONCLUSION

The data contained in the tables of this paper indicate that there has been a significant decline in applicants to dental school from the period of 1974 to 1978. It also indicates that this decline has been significantly greater among applicants from the socio-economic lower middle income class, i.e., applicants whose fathers possess only a high school education or less and whose parents are only able to contribute $2,000 or less towards the expenses of their dental education. Table 4 clearly indicates that during this same period there has been a substantial increase of 125% in the average tuition costs for dental education. (This cost does not include room, board, books, fees or instruments.) Table 5 reports that as tuition has been increasing, federal capitation support has been declining at almost the same rate. This decline in both capitation and applicants from the socio-economic lower middle class and the high increase during the same period in tuition costs demonstrates a significant negative correlation between thw two declining factors and the one rising factor. That is, as capitation has decreased, tuition tends to rise and as tuition rises, the decrease in applicants from the socio-economic lower middle class has become greater.

This conclusion has tremendous implication for the effect that total withdrawal of federal capitation would have on the dental care delivery system in the United States. From other studies (3) where it has been shown that the place of rearing has the strongest influence on the choice of practice location, the above conclusions indicates that the present mal-distribution problem in the dental care delivery system will increase. As the decline in applicants from the socio-economic lower middle income class increases, there will be fewer dental graduates who come from shortage areas and, therefore, fewer willing to eventually relocate their practice back in these areas.

REFERENCES

(1) American Dental Association, Annual Report, Dental Education. 1975-78

(2) American Dental Association, Annual Report, Dental Education, Supplement 4, Financial Report. 1975-78

(3) Graham, J., Factors Influencing the Choice of Practice Location for Recent Dental Graduates. JADA. Vol. 94, May 1977, p. 821 ff.

Enclosure #2

STATEMENT OF
THE AMERICAN DENTAL ASSOCIATION
ON
THE NATIONAL HEALTH SERVICE CORPS
(Summary of Recommendations)

I. The NHSC Scholarship Program:

- The number of scholarship recipients must be linked to a careful evaluation of the need for NHSC dentists in legitimate shortage areas which cannot be served by existing private resources;
- The selection process must be linked to the nature of the shortage areas. Participants should be those most likely to remain in shortage areas rather than those with greatest financial need. Priority for granting of scholarships should be second year students.

II. The Health Manpower Shortage Area (HMSA) Designation Process:

- Require that all requestors of designations consult both the appropriate HSA and local professional society and include their comments when submitting the request;
- Information requested from the professional society or any other relevant organization, should allow for a reasonable comment period - i.e. not less than 90 days;
- The criteria for designation of HMSAs must be improved to insure consistency in identification of shortage areas and to assure that all relevant factors are considered in evaluating designation requests.

III. The NHSC Placement Process:

- Require applicants for personnel to contact the appropriate professional society before submitting an application to request assistance in dealing with the shortage through use of existing private resources. Require the professional society's response to be included in the application;
- When requesting information from a professional society or other relevant organization, the Corps should allow a reasonable period in which to comment - i.e. not less than 90 days from date of receipt;
- Prohibit placements which would preempt any efforts initiated by private resources to deal with the shortage;

- Where NHSC dentists are placed to deal with special population groups designated as having shortages, require that such personnel may serve only members of that population group.

- Require that placement priorities for dental personnel be based only on degree of shortage groupings and that special efforts be undertaken to achieve placements in areas in which no dentists at all currently practice;

- Dental placements should not be linked to the existence of integrated sites funded under section 330 - the arguments for tying medical placements to integrated sites are not valid for dentistry;

- In areas where it can be demonstrated that private dental practice is an economically feasible way to reach the population at risk, require that Corps dental placements be on the private practice model;

- Require that the local professional society be involved in the process of recruiting a Corps dentist to serve in an approved placement site;

- Require that all Corps dentists obtain a license to practice in the state in which placed at the earliest available opportunity.

Detailed Recommendations

I. NHSC Scholarship Program:

Officals of the NHSC program have indicated that, as of December 31, 1979, a total of 770 dental students have been awarded service scholarships. Several hundred more scholarships are expected to be allocated for dentistry over the next five years. To date, however, only 860 dental manpower shortage areas have been designated as eligible for the placement of one or more Corps dentist. There appears to be little coordination between the number of scholarships granted and projected for dentistry, and the actual need for Corps members to serve in shortage areas. It is also important to recognize that the number of Corps dentists required is a function not of the number of shortage areas but rather of the existence of a viable sponsor and a site in which those dentists can effectively serve.

Past experience suggests that the scope of the Corps dental program has not been determined by a careful analysis of the number of dentists who can be viably placed but by the number of scholarship students completing training. In the opinion of the ADA, this has resulted in a situation in which considerable pressure is exerted on the NHSC regional offices to identify sites for scholarship dentists, whether or not viable sites actually exist. Because the integrity of the site is crucial to a successful placement, some Corps dentists are thus placed in areas of marginal need. (Nearly half of all dental placements are in 03/04 priority areas.) It would also appear that some areas have been designated as dentally underserved simply because those areas have a fixed-site health center which could support Corps placements.

It is clearly not possible to forecast exactly the number of placements in viable sites which will exist several years in the future. It should be possible, however, based on the Corps' experience with several hundred dental placements, to make reasonably accurate projections of the number of scholarship graduates which it can effectively utilize. Establishing the number of scholarships to be granted on projected placement opportunities would help to ease the pressure for designation of marginal shortage areas and would allow the Corps to concentrate its efforts on meeting the needs of the most serious shortage areas.

The National Health Service Corps was designed as a temporary mechanism to help meet the health care needs of underserved populations, many of which are rural and/or face special ethnic, racial, and language barriers to access to existing resources. Clearly, it is important that Corps personnel be carefully selected for characteristics which would enable them to address the special needs of the populations they will serve. Such matching would result not only in more effective services during the placement period but also in a greater probability for retention in the shortage area once the service commitment has been completed.

In selecting scholarship recipients, the program does appropriately give consideration to personal background and work experience in shortage areas as well as to career goals. However, priority is given to entering freshmen. Unfortunately, freshmen, with little direct experience with the dental care system, may have career goals which will change with exposure to intensive clinical education. It is certainly desirable to make contact with potential scholars at the earliest feasible date. It is also important, however, not to lock students into a service commitment before they have begun to develop an understanding of what that commitment entails.

It would be advisable therefore, to focus on the sophomore year as the preferred point for granting scholarships. The freshmen year could then be utilized as a period of intensive recruitment and education so that those seeking scholarships in the sophomore year would be equipped with a better understanding of what that commitment means for them upon graduation. This should result in fewer obligated graduates who find that service in the Corps is unsuitable to their personal or professional goals.

An additional problem in the selection of scholarship recipients is the issue of need for financial support. In some cases, those students who are most likely to serve effectively in shortage areas may indeed be those who also have the greatest financial need. However, there also appears to be a correlation between need for support and tuition costs of individual dental schools which is unrelated to the characteristics of students. It is very important, therefore, that NHSC scholarships not become a subsidy to those dental schools whose tuitions are highest. Not only is financial need an unreliable indicator of appropriateness for service in shortage areas, it is also a selection criteria which could have the undesirable effect of pushing low-income students into practices in underserved areas while more affluent students are able to pursue their respective careers unencumbered by shortage area service. There must be sufficient alternative sources of financial support to allow low-income students reasonable choices in selecting career orientations. Financial need should be deemphasized as a selection criteria for NHSC scholarships and should, in any case, be determined independently of differing dental school tuitions.

II. The Health Manpower Shortage Area (HMSA) Designation Process:

The point at which shortage areas are actually designated is perhaps the single most crucial point in the entire National Health Service Corps program. Corps personnel may only serve in areas which have been designated as Health Manpower Shortage Areas for the appropriate type of care (e.g.: medical, dental, etc.). It is thus of vital importance that areas designated as shortage areas be those which unquestionably do not have adequate resources to serve their populations. The two components of the health care system which are most likely to have the knowledge to assure that designations are appropriate are the Health Systems Agency and the local dental society or other relevant professional group.

Health Systems Agencies are invested with the responsibility for allocating scarce resources and for assuring that the health care system within each health service area provides accessible high quality care in the most cost-effective manner possible. As such, the HSA should have a comprehensive view of the needs of its health service area. The local dental society on the other hand, has the most complete view of the situation in terms of providing high quality dental care to the population. It has the best possible understanding of the local dental manpower situation and of the utilization of those resources. The American Dental Association has encouraged its constituent (state) societies to identify true dental shortage areas within each state and to match such areas with those identified under the National Health Service Corps Program. It is absolutely essential, therefore, that both the HSA and dental society perspectives be fully represented in the designation process.

Existing regulations specify that the HSA must be consulted by the Shortage Area Designation Staff before a final decision is made on a designation. The regulations do not require that the local dental society be involved at any point in the designation process.

Any applicant seeking designation of a dental shortage area should be required to consult both the appropriate Health Systems Agency and the appropriate local dental society prior to submission of a designation request. The applicant should be required to include in its designation request, documentation of that prior consultation as well as of the HSAs' and the dental societies' positions on the appropriateness of the request. Failure to do so should constitute grounds for denial of the designation request.

In order to ensure that the input of the HSA and the dental society is based on a comprehensive investigation of the proposed designation, each of those organizations should be allowed a reasonable period in which to evaluate the designation request - i.e., not less than 90 days from date of receipt. The Association respectfully recommends the adoption of appropriate statutory amendments to effect these changes.

The task of identifying areas with shortages of health manpower is a complex one. No two communities or population groups are exactly the same, no do they have identical health care needs. Therefore, it may not be possible to develop criteria for identifying shortages which are completely objective and quantifiable. The existing criteria for designation of dental shortage areas attempt to be objective in ways which often produce limiting and inaccurate results while providing too little objective guidance in certain other areas. The result has been considerable confusion and inconsistency in interpretation of the criteria and in the characteristics of the dental shortage areas which have actually been designated.

The American Dental Association's Bureau of Economic and Behavioral Research has prepared a detailed analysis of the criteria for designation of dental shortage areas, under contract to the Department of Health, Education and Welfare ("Assessing Supply of Dental and Auxiliary Personnel and Requirements for Dental Health Personnel by Specialty and Geographic Location,"). This analysis, which is included as an appendix to this statement offers a critique of specific aspects of the criteria and suggestions for improvements.

III. The Placement of National Health Service Corps Personnel:

Current regulations specify that the NHSC must solicit the comments of Health Systems Agencies and local professional societies on applications for placement of Corps personnel. The present comment period allowed these organizations is 30 days. As in the case of applications for designation of shortage areas, this regulated involvement of HSAs and professional societies is too little and too late.

Just as it is crucial that the appropriate HSA and local dental society be involved throughout the process of identification of shortage areas, so too, it is vital that they be involved in all efforts to alleviate shortages. The placement of NHSC dentists is only one of many potential strategies for meeting the needs of dental shortage areas. Among other alternatives are the redistribution of existing private dentists and the recruitment of new private dentists. (The ADA is sponsor of the National Health Professions Placement Network, which is designed to help meet just such needs.) Early involvement of both the HSA and the dental society can assure that the needs of shortage areas are met in the most cost-effective manner possible. It can also help to prevent costly duplication of resources. Clearly, it would be counterproductive to place an NHSC dentist in an area in which a private dentist is planning to open a new practice, yet such situations have occurred due to insufficient communications and cooperation. This results in substitution of a NHSC dentist for a private dentist with no increase in supply of services and in higher costs.

Any applicant seeking placement of NHSC dental personnel should be required to consult both the appropriate Health Systems Agency and the local dental society prior to submission of a placement request. The applicant should be required to include in its placement application documentation of that consultation as well as of the HSAs' and the dental societies' positions on the appropriateness of the proposed placement. Failure to do so should constitute grounds for denial of the application.

In order to ensure that the input of the HSA and the dental society is based on comprehensive investigation of the proposed placement, the current law must be amended to allow each of those organizations a reasonable period in which to evaluate the application - i.e., not less than 90 days from date of receipt.

The regulations now require that the Corps also solicit the comments of the State Health Planning and Development Agency on any placement request. Complimentary to requesting comment from the SHPDA, the state dental society's comments should also be solicited. This would assure comprehensive input from planning agencies and the dental profession at both state and local levels. In addition the Corps would be well advised to solicit the input of the Dental Director in each state's Department of Health.

The need to avoid duplication of private resources by NHSC personnel is of utmost importance. Therefore, the National Service Corps should be precluded from placing Corps dentists in areas which would preempt or compete with any reasonable efforts which have been initiated to deal with shortage situations through the use of private resources. Dentists who enter a shortage area to establish a private practice or to work in a private facility are far more likely to remain in the area than are dentists placed by the NHSC. Such private dentists are a preferred alternative for relieving shortages wherever possible.

A similar problem of potential duplication of resources exists where NHSC dentists are placed to serve special population groups. Under the regulations for designation, it is possible to designate shortage populations as well as geographic shortage areas. Such populations are often located in geographic areas which have adequate numbers of dentists to meet the needs of the majority of their populations. The special populations, however, have inadequate access to services because of socio-cultural factors such as language barriers. (The difficulties of accurately identifying socio-cultural access barriers were discussed earlier). Where this type of shortage population does clearly exist, care must be taken to ensure that any federal resources intended to alleviate the shortage are in fact utilized only by the shortage population.

It is inappropriate for National Health Service Corps dentists who are placed to serve a special population to be utilized by members of other groups who have access to private resources. Such a situation can result in unfair competition through providing care at lower than market-prices and thus would force private dentists to leave the area. This would have the unacceptable effect of actually worsening the area's manpower situation at the same time that the target population receives less than the maximum benefit intended by the Corps dentist. It should, therefore, be clearly specified in law that any NHSC dentist who is placed to serve a shortage population may provide non-emergency services only to members of that population group.

Congress must also ensure that NHSC dentists are placed in those shortage areas which have the greatest need. The existing criteria for HMSA designation provides for a system of grouping areas by degree of shortage, with the "01" classification representing the most critical shortage and "04" the least. In practice, however, the Department has assigned an unacceptably high percentage of Corps dentists to those areas designated as having a lower (03 and 04) priority. This results in part from the latitude allowed for site selection by NHSC dentists and, in particular, from the Corps' shift in emphasis to "integrated" delivery systems or fixed-site health centers as the preferred delivery mode. The Department has recently indicated that a majority (80%) of future Corps dental placements will be in Community Health Centers and other fixed-sites. Whatever advantages may be perceived to exist by adopting this approach, it is mitigated by the fact that, for dentistry, most of these sites are in the 03/04 priority areas. This policy has, in addition, the immediate effect of penalizing those rural and urban communities which do not have fixed-site health centers. Of most importance is the fact that the placement of Corps dentists in these semi-permanent facilities virtually precludes the conversion of this form of NHSC delivery mechanism to a private practice; an objective which was a central feature of the original NHSC legislation.

It is important to recognize that the solo practice model is the dominant characteristic of the dental care delivery system. Because of the profession's emphasis on primary care (almost 90 percent of dentists are general practitioners) referral relationships and other linkages which are necessary for medicine are less critical to dentistry. The validity of the dental private practice model as a long-term solution to access problems is demonstrated by the experience of the National Health Service Corps in HEW Region X (Alaska, Idaho, Oregon and Washington). Of eight private practice model NHSC sites established in Region X since 1972, seven have converted to successful private practices and the eighth is expected to follow this pattern. Based on this experience and on the nature of dental practice, the National Health Service Corps should be required to utilize the private practice model for dental placements in all shortage areas in which it can be demonstrated that private dental practice is an economically feasible way to reach the population at risk.

National Health Service Corps dentists must also be effectively integrated into their professional communities and thus encouraged to remain upon completion of the placement.

One way in which the professional relationships of Corps providers could be improved would be through greater involvement of local private dentists in the recruitment process. This would permit experienced dentists to bring their technical knowledge and understanding to bear in the selection process. It would also ensure that local providers were familiar with and confident of the new dentist at the outset of the placement, facilitating integration into the community as a whole. The NHSC should therefore be directed wherever possible to involve representatives of the local professional community in the recruitment process.

A more specific problem involves licensure. Each state has its own licensure requirements and it is essential that Corps dentists be licensed in the state of placement if they are to be respected and supported by their colleagues. In a number of cases, newly graduated dentists have been placed by the Corps and have then been unable or unwilling to obtain their licenses. The timing of graduation, placement schedules, and licensure exams may be such that dentists in some cases must be placed prior to taking the licensure exam. However, the Corps must do everything possible to minimize such situations, and it must not abide with dentists who are unable or unwilling to obtain their licenses. A serious question must be raised about the quality of care provided by a dentist who cannot or will not obtain a license. All National Health Service Corps dentists must be required to obtain a license to practice in the state in which placed at the earliest possible opportunity. No dentist should be placed who cannot be reasonably expected to do so and all efforts should be made to see that licensure precedes final placement wherever possible. Failure to obtain a license should be grounds for removal from placement.

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

EXECUTIVE COUNCIL
LANE KIRKLAND
PRESIDENT
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March 25, 1980

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
Committee on Labor and Human Relations
4220 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed is a copy of the AFL-CIO statement on bills to extend the Health Professions Educational Assistance Act of 1976.

We hope you will find this comment of interest and help. Would you please place this statement in the record of your subcommittee hearings.

Sincerely,

Ray Denison
Ray Denison, Director
DEPARTMENT OF LEGISLATION

Enclosure

STATEMENT SUBMITTED BY RAY DENISON, DIRECTOR, DEPARTMENT OF LEGISLATION
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
ON
BILLS TO EXTEND THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976
S. 2144, S. 2375 and S. 2378

March 25,1980

The AFL-CIO appreciates the opportunity given us by the Health and Scientific Research Subcommittee to submit our views on S. 2144 introduced by Senator Schweiker (R-Pa.), S. 2375 by Senator Kennedy (D-Mass.) and S. 2378 by Senator Javits (R-N. Y.).

The first two bills would extend and improve the Health Manpower Act of 1976. The bill introduced by Senator Javits would supplement and complement S. 2375.

The present law, the Health Professions Educational Assistance Act of 1976, was a giant step forward over the 1963 law which was designed to increase the number of physicians and other health professionals. The success of the 1963 law is apparent. More medical schools were constructed. All schools of the health professions -- medical schools as well as schools of dentistry, optometry, podiatry, pharmacy, veterinary medicine, nursing, public health and of the allied health professions -- have greatly increased the supply of health personnel.

The assumption in the '60s was that an increase in the supply of health professionals, particularly physicians, would lead to more competition and this competition, in turn, would tend to hold down doctor fees and lead to a migration of medical graduates into under-doctored rural and inner city areas and into primary care.

This laissez-faire theory has been a woeful failure in practice. Geographic and specialty maldistribution has continually worsened despite the billions of dollars pumped into medical schools to turn out more physicians.

Many economists have noted that the health care industry does not fit the classic competitive model. If supply and demand meant anything in the medical care market, physician fees in Washington, D. C., should be the lowest in the country since Washington has an ample supply of doctors -- one for every 296 persons. This is not the case. In fact, fees are higher in the District than in other areas of the country. The under supply of doctors in rural areas should mean, by supply and demand analysis, that their fees and incomes would be higher than their urban counterparts. Yet, the reverse is true.

The over supply of surgeons has not resulted in lower incomes for surgeons. Rather it has resulted in more surgery. Surgeons in the United States operate twice as much in relation to population as in England. Doctors have not flocked into primary care practice because it is not as financially rewarding as specialty practice. Moreover, routine health maintenance services and taking care of chronic patients, the great bulk of primary medical practice today, is rather dull in comparison with more exciting acute, life-threatening illness. Also, physicians receive their internship and residency training in hospitals taking care of patients with acute illness. As a result, their interest and concern in routine health maintenance and preventive care is minimal. Up until the revised Health Manpower Act of 1976 was enacted, there were no departments of family practice in our medical schools.

As the numbers of health personnel increased, so did the problems of overspecialization and maldistribution. The Health Manpower Amendments of 1976 were designed to overcome these problems. Today most medical schools have departments of family practice and/or community medicine. About half of the students are graduating in the primary care fields of family practice, internal medicine or pediatrics. The geographic distribution of physicians has improved through the National Health Service Corps and the student scholarship and loan forgiveness programs authorized by the 1976 amendments which provided financial incentives for medical school graduates to practice in underserved areas.

However, experience under the 1976 act indicates the legislation can be further improved. For example, the Annals of Internal Medicine for August 1979 reports almost 70 percent of internal medicine residents taking advantage of these financial incentives continue with one to three years of subspecialty training. On the other hand, evidence to date indicates the bulk of family practice residents do, in fact, enter family practice. If this is the case, and it is not yet proven, it indicates that the proposed amendments to the Manpower Act should give a priority for scholarships and loans to those students choosing family practice over other primary care specialties.

Another weakness of the present law is that it apparently does not provide adequate financial incentives to minorities and women to undertake a medical education because these groups are still under-represented in the student bodies of our medical schools.

S. 2375 addresses this concern as well as others that are widely recognized, such as:

- The need for increased number of primary care physicians
- The desirability of decentralizing a portion of the educational experiences into community settings to counterbalance the strong incentives toward specialization and subspecialization.
- The need to place more emphasis on prevention and cost containment.
- The importance of developing interest among students to enter careers as clinical investigators.
- The need to increase nursing school enrollments
- The importance of discouraging excessive tuition and enrollment increases in our medical schools.

The AFL-CIO strongly supports the principal thrust of S. 2375 which would eliminate capitation grants to the health professions schools by which grants are provided to each eligible school proportionate to enrollment. Instead of capitation grants, the bill authorizes a new program to provide significant incentives to the health professions schools to meet national objectives. The level of support to each school would be related to increased representation of minority students and women, improved geographic and specialty distribution of graduates and curriculum improvement. In other words, current law uses capitation payments to the schools as a club to induce medical, nursing and other health professions schools to meet national objectives. Unless the schools do this, their capitation payments would be cut off. H. R. 2375 offers the carrot approach to accomplish the same objectives. The AFL-CIO favors the incentive approach.

The bill also provides project grants for planning, development, operation and maintaining training programs in family medicine; for programs to train physician assistants; to provide educational assistance to individuals from under-represented minority groups, women and those with disadvantaged backgrounds; to meet the needs of medically underserved populations; and for various research and demonstration projects. It also provides distress grants to professional schools in financial trouble.

S. 2144 has similar goals and objectives as S. 2375 but provides minimal institutional support to replace capitation grants to health professions schools under present law. The bill would also phase out the National Health Service Corps program. Another important difference is that the Secretary of the Department of Health, Education and Welfare would make grants to the states to administer a state service scholarship program. Under this program, the states would require one year of service in a medically underserved area for each year of scholarship assistance. The bill also repeals the exceptional need scholarship program of present law which provides financial assistance for students who otherwise could not afford a medical education.

Over the years, state and local governments have been the source of an increasingly larger share of the fiscal support for medical education. In 1977, state and local contributions to medical education had grown to $859 million, or 22 percent of the schools' revenues. However, the record of these state programs has been very spotty. Some have been quite successful in inducing physicians to fulfill their service obligations in underserved areas and others have failed.

The AFL-CIO, therefore, favors federal administration of scholarship programs, at least until such time as state programs can be thoroughly evaluated.

An excellent provision of S. 2144 is that the bill would provide special project grants and contracts to medical schools for training medical students in medical economics.

S. 2378 would add three additional provisions which would:

- Provide financial support to traineeships in health administration to develop management skills.
- Support innovative educational programs to increase the amount of residency training in ambulatory care settings in teaching hospitals or in organized ambulatory care settings such as Health Maintenance Organizations.
- Relax certain restrictions in current law on the entry of Foreign Medical Graduates (FMGs) into the United States.

The AFL-CIO can wholeheartedly support the first two as improvements to S. 2375, but have concerns about the third. The AFL-CIO recognizes the importance of FMGs to many hospitals. For example, FMGs occupy more than 50 percent of housestaff (interns and residents) positions in 18 hospitals in New York City. However, the AFL-CIO is concerned about the "brain drain" in foreign countries of their best medical students. The AFL-CIO is also concerned that the training these FMGs receive in acute intensive care hospitals in the United States is not relevant to the medical care needs of the people of the countries from which many of these students come.

In conclusion, the AFL-CIO strongly supports S. 2375 which should have incorporated into it the specified improvements we favor from S. 2144 and S. 2378. We hope such a bill can emerge from this subcommittee and be reported to the floor by the full Labor and Human Resources Committee for enactment in this session of Congress.

WASHINGTON
UNIVERSITY
IN ST. LOUIS

Office of the Chancellor

March 13, 1980

The Honorable Howard M. Metzenbaum
United States Senate
342 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Metzenbaum:

Dr. Robert Q. Marston and I appreciated the opportunity to speak at the hearings on health manpower Wednesday.

You raised an interesting question about what physicians could do that would be of benefit to medical education, especially at a time when there are valiant attempts to balance the federal budget.

I believe that you might be interested in how physicians are helping at Washington University:

1) The full-time salaried physicians are engaged in clinical practice in excess of that required for academic reasons. The money so earned goes to the School of Medicine to underwrite our costs. In the last seven years income from this source has increased fourfold. It accounts for 22 percent of the income of the School of Medicine, up from 14 percent seven years ago. This figure excludes the Department of Radiology which is separately budgeted. (During this period the percentage of the total income of the Medical School coming in federal grants and contracts has declined from 54 percent to 36 percent.) These physicians are, in fact, doing their share to fund the School of Medicine. From my standpoint they are of necessity doing too much so that less time and energy are available for teaching and research.

2) Approximately 690 physicians in private practice give time on a voluntary basis, totally free of charge, to the teaching and service programs of our medical center.

3) Last year 1,670 of our physician alumni made contributions to Washington University Medical School totalling $330,913.

I understand well your concern with the federal budget. I do want to add this postscript to our testimony.

Thank you again for your courteous and efficient chairing of the session.

Yours sincerely,

Wm Danforth

William H. Danforth
Chancellor

Boston University Medical Center

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Office of the Dean

STATEMENT OF JOHN I. SANDSON, M.D., PROFESSOR AND DEAN, BOSTON UNIVERSITY SCHOOL OF MEDICINE, BEFORE THE SENATE HUMAN RESOURCES COMMITTEE TO BE INCLUDED IN THE HEARING RECORD ON THE REAUTHORIZATION OF HEALTH MANPOWER LEGISLATION--MARCH 1980.

Mr. Chairman and Members of the Committee:

My name is John Sandson and I am Dean of the Boston University School of Medicine. I am grateful for the opportunity to have this statement included as part of the record during your deliberations on the reauthorization of health manpower legislation.

Boston University School of Medicine is particularly concerned with several aspects of the present law that must be reauthorized by September 30 of 1980. Those areas are:

1) Student assistance
2) National Health Service Corps Scholarship Program
3) Institutional Support Program, and
4) Special Project Support (including programs for minority and disadvantaged students and Area Health Education Centers)

We believe that the most effective approach to the reauthorization of each of these key areas is embodied in S.2375, the Health Professions Training and Distribution Act of 1980.

1) Student Assistance

Present programs to help medical students finance their education are inadequate. Students currently enrolled in private medical schools need approximately $12,000 per year to meet expenses. That figure will become about $14,000 for the 1980 entering class this fall. For students who need to borrow in order to finance their education, the current system requires that they obtain loans from several different sources. New regulations for the Health Professions Student Loan Program now require that only students with NO FINANCIAL RESOURCES are eligible. The average student entering medical school this year will need to borrow $10,000 in the first year. The current system requires that the student obtain loans from many different sources, each with different interest rates and different payback provisions. The result is that students are often confused and frustrated by the process of acquiring the many different loans necessary to cover the $50,000 needed for their education.

The Health Education Assistance Loan (HEAL) Program, initiated by the Administration several years ago, provides 50% of the students an opportunity to borrow up to $40,000 at 12% to 14% interest rates. Students who borrow from the HEAL program are prohibited from borrowing from ANY OTHER government program. The payback begins after three years of residency and extends for 15 years. Conservative estimates are that the student borrowing $40,000 will be obligated to pay back $140,000 to $150,000. Many observers in both the medical profession and in government believe the negative effect of this program on physician fees and the cost of health care in the future could be significant.

S.2375 provides a far better range of options for students in need of loans to finance their medical education. It extends federal authority to provide insured loans to students in health professions schools and increases the maximum borrowing limit. It removes the restriction in the present law that would prevent a student under the HEAL program from borrowing under the guaranteed student loan program and other available government loan programs. It further creates a new service-contingent, need-based loan program providing government subsidized loans to health professions students at 7% and 5% depending on the type of professional school the student attends. In return for interest subsidization, the student may be called to national service in a medically underserved area by the Secretary in the first year of the loan repayment period. A student's loan obligation would be discharged by such service. The significance of a program of this nature is twofold. First, it creates reasonable financing on a need basis for low- and middle-income students who presently have few options. Second, it provides the Secretary with a reserve of health manpower available for service in underserved areas should the numbers of health professionals in the National Health Service Corps be inadequate to meet national needs. Finally, S.2375 continues the exceptional financial need scholarship program for first-year students, thus providing a wide range of options for students from varying income groups. The Health Professions Student Loan monies currently available as revolving loan funds are critical to most schools and should not be eliminated.

2) The National Health Service Corps Scholarship Program

Coupled with these loan programs and the exceptional financial need scholarship program, S.2375 continues the National Health Service Corps Scholarship Program. To date, the NHSCS Program is the most effective federal effort aimed at solving the geographic maldistribution of physicians and the consolidation of its administration with that of the National Health Service Corps under one administrative unit, as is proposed in the Health Professions Training and Distribution Act of 1980, will go a long way toward improving the relationship between the Scholarship Program and the Corps in itself. Also, the bill substantially improves and enhances the option for National Health Service Corps scholarship recipients to fulfill their obligations through an independent practice arrangement. As the cost of maintaining Corps members in the field continues to increase, incentives to choose the private practice option will help to control ever-rising demands of the Corps for increasingly limited health manpower dollars.

3) Institutional Program Incentive Support

Institutional grants were first made available to medical schools under Section 770 of the Health Manpower Act of 1971. At that time the intent of Congress with regard to this section was to substantially expand the capacity of American medical schools. This expansion program was extremely successful. The aggregate entering medical class size in 1976 was approximately twice what it was in 1969 but has increased only slightly since 1976. In 1976, realizing that adequate expansion of medical school class size had probably been achieved, this Committee reported and the Congress passed the Health Professions Education Assistance Act of 1976. Section 770 of that Act authorized the continuation of institutional grants to medical schools but changed the purpose for which those grants were awarded: first, fifty percent of first-year housestaff positions were to be in primary care; and, second, a one-time 5% expansion in third-year class size was to occur to incorporate into the American medical education system American citizens transferring from foreign medical colleges. Both of these provisions have been successfully fulfilled by almost all medical schools in the country.

Despite the success of the capitation program, it has come under much criticism for the past several years. However, it is our belief that the partnership created between the health professions schools and the federal government by a program of institutional support is crucial to insure that medical schools pursue national goals designed to address specialty and geographic maldistribution--two areas directly linked to the availability and cost of medical care in this country. I would like to quote a 1978 General Accounting Office report on this subject: ".....A loss of capitation would lower the quality of medical education. An additional concern...(is)...that a loss of capitation and a subsequent increase in tuition would result in changing the socio-economic characteristics of the student body because only students from affluent families could afford the increase." Furthermore, GAO states, ".....Present indications are that state governments are looking for ways to reduce state funding to medical schools...(and)...endowments are generally restricted to particular departments or programs within the schools of medicine and would be precluded for use in the types of activities...capitation funds are currently used for, namely the support of faculty positions to facilitate initiatives in the areas of specialty maldistribution, geographic maldistribution, and curricular reforms."

S.2375 would repeal the present health professions capitation grant program and would establish a new national priority incentive grant program awarding annual grants to health professions schools for the purpose of supporting their educational programs, and projects and activities that are in the national interest. For schools of medicine, the amount of the award would decrease should the school substantially increase class size or excessively increase tuition. The amount would increase for schools of medicine if objectives are met related to: enrollment of underrepresented minority groups and women; graduation of students entering family practice; increase percentage of residency training positions in primary care; enrollment of students from health manpower shortage areas; offering of education programs in nutrition, geriatrics, prevention, health care economics or rehabilitation; and preparation of students to pursue careers in clinical investigation. We believe that this type of incentive grant program is a reasonable alternative to the capitation program. It specifically addresses national needs and provides a mechanism by which the Congress can reward those schools that choose to address areas of national need while discouraging schools from further class expansion. Medical schools have not increased tuition without careful consideration of alternatives; great care needs to be taken before tuition increases are judged to be excessive.

4) Special Projects

The Health Professions Training and Distributions Act of 1980 consolidates, extends and expands special project grants and contracts to health professions schools with much needed emphasis on primary care and family practice training programs, training programs for non-M.D. health professionals, paraprofessionals and allied health personnel, area health educational centers, health professions faculty development, programs to encourage individuals from underrepresented minority groups and disadvantaged backgrounds to enter health professions schools, and training in nutrition, geriatrics, rehabilitation and the containment of health care costs, among others. We believe that these proposed changes in special programs are necessary and will effectively increase the availability of such programs in schools throughout the country, thus significantly improving the quality of medical education in areas that have been determined to be of great national importance.

In summary, Boston University School of Medicine supports the Health Professions Training and Distribution Act of 1980 as the most comprehensive legislation introduced in the 96th Congress on the subject of health professions education. We believe that the availability of quality health care at a reasonable cost to all Americans is, in part, dependent on the quality and type of medical manpower available to meet the nation's needs. Furthermore, we believe that continued increases in the cost of education in the health professions, coupled with inadequate scholarship and loan programs could severely limit the access of a large portion of our population to the health professions. We believe that the nation's health manpower is a national resource and that it is appropriate that the federal government be involved in the growth and development of that resource to help insure that it serves the national good.

It is our belief that S.2375, the Health Professions Training and Distribution Act of 1980, would create a reasonable and necessary partnership with health professions schools, students, and federal government in order to insure that all Americans have equal opportunity to elect a health career and that no American is denied access to appropriate, quality health care.

GEORGETOWN UNIVERSITY
WASHINGTON, D.C. 20057

OFFICE OF THE PRESIDENT
SPECIAL ASSISTANT FOR
FEDERAL RELATIONS

202/625-4011

Honorable Edward M. Kennedy
Chairman, Subcommittee on Health and Scientific
Research
U.S. Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Enclosed please find a copy of a comprehensive program for health education student loans. Please admit this to the record as testimony on Senate Bills S2144, S2375 and S2378.

On behalf of our President, Rev. Timothy S. Healy, S.J., we would like to thank you for your time and consideration.

Sincerely,

T. Byron Collins, S.J.

T. Byron Collins, S.J.

March 13, 1980

Proposed is a three point loan program for all health professions students, exclusive of nursing students.

1) The HEAL program would be continued except that it would be allowed to be mixed with other loans for which a student might be eligible and will be set at current market rates.

2) A federally subsidized guaranteed student loan program based on financial need would be established. Eligibility as to neediness of the student will be determined by the institution where the student is enrolled. A priority will be given to students with the greatest total amount of unmet financial need. Unmet financial need is equal to the cost of tuition, books, fees and reasonable living expenses less parental contribution, student earnings and Health Professions Student Loan money. Those students participating in the National Health Service Corps and the Armed Forces Health Professions Scholarship Programs would have their total educational costs met and would thus be excluded from the pool of students with unmet financial need. During school, internship and residency, students would pay 7% interest and the federal government would pay the balance between 7% and the market rate which would not be allowed to exceed 15%.

If a health professional establishes an independent practice in a designated health manpower shortage area, he or she would receive a complete loan interest subsidy where the federal government would pay the annualized interest on his or her loan. If health professional does not establish practice in a designated health manpower shortage area, his or her low interest rate would go to the market rate which would not be allowed to exceed 15%.

3) A federally subsidized guaranteed student loan program based on an agreement to work in a health manpower shortage area in the Public Health Service, if called by the Secretary of Health and Human Services.

During school, internship and residency, students would pay 7% interest and the federal government would pay the balance between 7% and the market rate which would not be allowed to exceed 15%

If called to service by the Secretary of Health & Human Services, a health professional would provide one year of service for each year that he or she received an interest subsidized loan during school. There is a minimum obligation of two years service if called. If selected, a student would receive one year of total debt forgiveness pro-rated at 25% per year for each year of service.

If not called and a health professional establishes an independent practice in a health manpower shortage area, he will receive a complete loan interest subsidy where the federal government will pay the annualized interest on his loan. If not called, and a health professional does not establish practice in a designated health manpower shortage area, his or her loan interest rate would go into the market rate which would not be allowed to exceed 15%.

In addition to the three point loan program, monies now used by medical and dental schools under the Health Professions Student Loans Program shall be retained by each respective medical or dental institution as a fund to pay for student loan defaults without any additional Federal Capitol contribution to the institution.

SPECIAL PROVISIONS:

1) HEAL, Financial Need Based Loans, and Service-Contingent Based Loans may be mixed with any other loans or financial aid for which a student may be eligible.

2) Financial Need Based Loans shall be distributed in such a way as to give the student with the greatest total amount of unmet financial need, priotity. Unmet financial need is equal to the cost of tuition, books, fees and reasonable living expenses less parental contribution, student earnings and Health Profession Student Loan money. Those students participating in the National Health Service Corps and the Armed Forces Health Professions Scholarships Program would have their total educational costs met and would thus be excluded from the pool of students with unmet financial need.

3) Students would not be allowed to defer and eliminate provision which allows students to defer compound interest and service contingent based loans, but would be expected to pay any interest accured each year.

A Proposed Three Point Student Loan Program For Health Professions Education (Exclusive of Nursing Students)

AUTHORIZATION: $300 million

Heal	- $50 million
Financial Need Based Loans	- $150 million
Services - Contingent Based Loans	- $100 million

STUDENT LOAN LIMIT:

Heal - $20,000/yr. or $80,000 aggregate
Financial Need Based Loans - $15,000/yr or $60,000 aggregate
Services - Contingent Based Loans - $15,000/yr or $60,000 aggregate

ANNUAL RATE OF INTEREST:

Heal - $91-day T-Bills + 2%
Financial Need Based Loans - $91-day T-Bills + 2% ≐ 15%

During Training

Student Interest Rate - 7% per annum
Federal Subsidy - 8% per annum

If Independent Practice in HMSA

Student pays no interest
Federal Subsidy - 15%

Services - Contingent Based Loans - $91-day T-Bills + 2% ≐ 15%

During Training

Student Interest Rate - 7% per annum
Federal Subsidy - 8% per annum

If Independent Practice in HMSA

Student pays no interest
Federal Subsidy - 15%

AVERAGE STUDENT LOAN: $7,000/yr for four years

ANNUAL REPAYMENT OF LOAN:

Heal - (Assuming 15% annual interest)
$12,225/yr or $1,019/mo. for 15 years

$183,375 aggregate
Financial Need Based Loan -
With subsidized interest for -
practicing in HMSA: $1,867/yr or $155/mo. for 15 years

(Annual Repayment of Loan)

$28,000 aggregate
Without subsidized interest for -
$91,000 aggregate
practicing in HMSA: $6,067/yr or $506/mo for 15 years

SERVICE CONTINGENT BASED LOANS:

Without Subsidized interest for -

practicing in HMSA: $1,867/yr or $155/mo for 15 years
$28,000 aggregate
Without subsidized interest for -
$91,000 aggregate
practicing in HMSA: $6,067/yr or $506/mo for 15 years

A COMPILATION OF STATISTICS CONCERNING
U.S. MEDICAL SCHOOLS,
PUBLIC HEALTH SERVICE SCHOLARSHIPS,
AND
ARMED FORCES HEALTH PROFESSIONS SCHOLARSHIPS

689

1789

Georgetown University
Washington, D.C.
Office of Federal Relations

Office of Federal Relations GEORGETOWN UNIVERSITY Washington, D.C.

MEDICAL SCHOOLS IN THE UNITED STATES OF AMERICA

	Number of Medical Schools	Enrollment	Average of Tuition and Fees
Private	51	25,515	$7,135
Public	74	38,192	Resident: $2,214; Nonresident: $4,117
Total	125	63,707	NA

HEALTH MANPOWER SHORTAGES, BY AREAS
(PRIMARY CARE)

	Number of Areas	Population of Areas	Practitioners Needed
Urban Areas	484	18,975,337	5,968
Rural Areas	1226	18,622,289	5,368
Total Areas	1710	37,597,626	11,336

SCHOLARSHIP AID

Public Health Service Scholarships	Total	3693
Armed Forces Health Professions Scholarships	Total	3548

STATE	REGION	MEDICAL SCHOOLS	ENROLLMENT	AVERAGE OF TUITION & FEES	P.H.S. SCHOLARSHIPS	P.H.S. NEED	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
		Total Public Private	Total Public Private	Public (1) Resident / Out of State Private	(2)	Total Areas / Total Need Urban Areas Rural Areas (3)		
ALABAMA	IV	2 2 0	945 945 0	2149 / 2749 NA	57	56 / 386 13 43	33	84
ALASKA	X	0 0 0	0 0 0	NA / NA 0	0	15 / 37 0 15	2	0
ARIZONA	IX	1 1 0	324 324 0	1370 / 3300 NA	5	19 / 125 4 15	12	17
ARKANSAS	VI	1 1 0	546 546 0	1695 / 3265 NA	30	38 / 159 6 32	27	28
CALIFORNIA	IX	8 5 3	4090 2545 1545	874 / 3434 7004	314	87 / 852 52 35	29	88
COLORADO	VIII	1 1 0	525 525 0	2565 / 14635 NA	61	31 / 68 7 24	7	28

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
CONNECTICUT	I	2	785	2200 / 2600	56	17 / 147	7	13
		1	340			16		
		1	445	6000		1		
DELAWARE	III	0	0	NA / NA	0	4 / 17	4	0
		0	0			2		
		0	0	NA		2		
DISTRICT OF COLUMBIA	III	3	1899	NA / NA	473	1 / 106	3	214
		0	0			1		
		3	1899	12772 (4)		0		
FLORIDA	IV	3	1404	1393 / 3381	70	35 / 293	16	129
		2	768			12		
		1	636	6150		23		
GEORGIA	IV	3	1234	1290 / 2505	88	71 / 337	7	146
		1	728			16		
		2	506	3973		55		
HAWAII	IX	1	300	750 / 1800	18	1 / 2	0	7
		1	300			0		
		0	0	NA		1		

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
		0	0	NA / NA		15 / 36		
IDAHO	X	0	0		0	1	6	0
		0	0	NA		14		
		7	4076	2434 / 6439		55 / 681		
ILLINOIS	V	2	1597		279	26	2	121
		5	2479	7336		29		
		1	1220	1340 / 3000		32 / 261		
INDIANA	V	1	1220		32	10	8	48
		0	0	NA		22		
		1	700	1460 / 3284		41 / 152		
IOWA	VI	1	700		109	2	7	111
		0	0	NA		39		
		1	626	3023 / 6023		21 / 56		
KANSAS	VII	1	626		18	5	7	38
		0	0	NA		16		
		2	992	1398 / 3098		62 / 274		
KENTUCKY	IV	2	992		40	5	25	44
		0	0	NA		57		

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
LOUISIANA	VI	3 2 1	1724 1123 601	1213 / 4215 8086	88	28 / 238 7 21	23	103
MAINE	I	0 0 0	0 0 0	NA / NA NA	33	14 / 34 0 14	6	0
MARYLAND	III	3 2 1	1424 914 510	2939 / 3439 (3) 3630	80	25 / [illegible] 14 11	21	36
MASSACHUSETTS	I	4 1 3	2267 400 1867	1220 / NA 8072	310	32 / 310 29 3	22	71
MICHIGAN	V	3 3 0	.2519 2519 0	4007 / 5715 NA	212	44 / 462 19 25	7	70
MINNESOTA	V	3 2 1	1329 1163 166	3060 / 8405 4980	61	18 / 30 6 12	8	32

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Residen' / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
		1	607	1655 / 2480		51 / 322		
MISSISSIPPI	IV	1	607		36	7	19	64
		0	0	NA		44		
		4	2106	2875 / 4795		46 / 369		
MISSOURI	VII	2	941		335	7	10	282
		2	1165	6736		39		
		0	0	NA / NA		18 / 36		
MONTANA	VIII	0	0		0	0	5	0
		0	0	NA		18		
		2	986	1403 / 2453		30 / 78		
NEBRASKA	VII	1	546		50	1	4	96
		1	440	5645		29		
		1	192	2600 / 6200		27 / 65		
NEVADA	IX	1	192		10	14	9	11
		0	0	NA		13		
		1	198	NA / NA		4 / 12		
NEW HAMPSHIRE	I	0	0		46	0	1	11
		1	198	9630		4		

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STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
NEW JERSEY	II	2 2 0	979 979 0	4650 / 5775 NA	125	21 / 148 18 3	11	24
NEW MEXICO	VI	1 1 0	300 300 0	1055 / 2478 NA	27	9 / 21 0 9	13	30
NEW YORK	II	12 4 8	6790 2218 4572	3397 / 4917 7052	475	83 / 1069 43 40	50	131
NORTH CAROLINA	IV	4 2 2	1674 753 921	1032 / 2814 3612	99	52 / 365 10 42	11	94
NORTH DAKOTA	VIII	1 1 0	216 216 0	1317 / 2165 NA	12	28 / 61 0 28	4	12
OHIO	V	6 5 1	3008 2406 602	2973 / 4810 5524	253	34 / 412 17 17	13	113

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
OKLAHOMA	VI	2 1 1	768 724 44	1594 / 3487 7080	37	31 / 223 9 22	25	62
OREGON	X	1 1 0	469 469 0	2376 / 5153 NA	46	32 / 111 6 26	4	20
PENNSYLVANIA	III	7 1 6	4440 388 4052	3673 / 8795 8637	647	64 / 353 22 42	23	305
RHODE ISLAND	I	1 0 1	245 0 245	NA / NA 7210	42	7 / 42 6 1	3	13
SOUTH CAROLINA	IV	2 2 0	755 755 0	1430 / 2990 NA	39	30 / 301 6 24	11	78
SOUTH DAKOTA	VIII	1 1 0	220 220 0	3948 / 3948 NA	15	47 / 95 0 47	13	21

STATE	REGION	MEDICAL SCHOOLS	ENROLLMENT	AVERAGE OF TUITION & FEES	P.H.S. SCHOLARSHIPS	P.H.S. NEED	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
		Total Public Private	Total Public Private	Public Resident / Out of State Private		Total Areas / Total Need Urban Areas Rural Areas		
TENNESSEE	IV	4	1684	1757 / 3157	273	44 / 222	16	147
		2	767			8		
		2	917	4974		36		
TEXAS	VI	7	3787	694 / 1316	144	75 / 535	65	229
		6	3151			28		
		1	636	4330		47		
UTAH	VIII	1	400	2570 / 4638	26	7 / 23	7	42
		1	400			2		
		0	0	NA		5		
VERMONT	I	1	327	2905 / 8005	27	9 / 18	5	18
		1	327			0		
		0	0	NA		9		
VIRGINIA	III	3	1451	2710 / 5030	184	47 / 265	13	145
		2	1195			4		
		1	256	7400		43		
WASHINGTON	X	1	734	1144 / 3834	31	31 / 281	18	47
		1	734			10		
		0	0	NA		21		

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STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. FOR SCHOLARSHIPS
WEST VIRGINIA	III	2	400	611 / 1394	43	51 / 270	32	22
		2	400			7		
		0	0	NA		44		
WISCONSIN	V	2	1322	2628 / 4517	107	34 / 137	7	63
		1	650			6		
		1	682	6025		28		
WYOMING	VIII	0	0	NA / NA	3	11 / 28	0	0
		0	0			0		
		0	0	NA		11		
AMERICAN SOMOA	IX	0	0	NA / NA	0	2 / 9	0	0
		0	0			0		
		0	0	NA		2		
GUAM	IX	0	0	NA / NA	0	0 / 0	0	0
		0	0			0		
		0	0	NA		0		
NORTHERN MARIANA ISLANDS	IX	0	0	NA / NA	0	1 / 3	0	0
		0	0			0		
		0	0	NA		1		

STATE	REGION	MEDICAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE OF TUITION & FEES Public Resident / Out of State Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas / Total Need Urban Areas Rural Areas	P.H.S. BUDGET ALLOTMENT	A.F.H.P. SCHOLARSHIPS
PUERTO RICO	II	2 1 1	720 589 131	591 / NA 8219	132	16 / 199 0 16	49	28
TRUST TERRITORY	IX	0 0 0	0 0 0	NA / NA NA	0	4 / 28 0 4	2	0
VIRGIN ISLANDS	II	0 0 0	0 0 0	NA / NA NA	0	2 / 16 0 2	0	0
RELEVANT TOTALS		Total 123 Public 74 Private 51	63707 38192 25515	(6)	5695	Total 1710 / 11,336 Urban 484 Rural 1226	732	3548

(1) All but one public university charge nonresident students more than state resident students. Eight private universities charge out-of-state students more than state residents. In these cases, the higher tuition rate was used in determining these averages.

(2) Figure is based only on those studying allopathy or osteopathy.

(3) "Urban" refers to areas within Standard Metropolitan Statisical Areas. "Rural" includes all areas outside of metropolitan areas.

(4) Tuition and Fees average based on Georgetown and the George Washington University Medical Schools only. Howard University Medical School receives a special, substantial subsidy.

(5) Tuition and Fees Average based on the University of Maryland Medical School only. The Uniformed Services University charges no tuition or fees.

(6) An average of tuition and fees is not presented here as it would be statistically misleading, giving equal weight to a state with one medical school as one with many more. An average of tuition and fees for medical schools is presented on the cover sheet to this table.

A Compilation of Information
on
U.S. Dental Schools,
Public Health Service Scholarship Program
and
Dental Manpower Shortages

1789

Georgetown University
Washington, D.C.
Office of Federal Relations

The purpose of the attached statistics is to present a compilation of information concerning U.S. Dental Schools, the Public Health Service Scholarship Program, and the Public Health Service Dental Manpower Shortages, not previously available in any one source.

The National Data Sheet, which follows on the next page is a summary of all of the information contained in Tables I and II. In Table I, those states with Dental Schools are listed with tuition and enrollment figures, broken down between public and private institutions. Table II is a listing of those states, territories, and possessions of the United States which do not have any Dental Schools, but which do have a shortage of dentists.

NATIONAL DATA SHEET

NUMBER OF DENTAL SCHOOLS IN THE U.S.A.

ALL DENTAL SCHOOLS	59
PUBLIC	36
PRIVATE	23

DENTAL SCHOOL ENROLLMENT

ALL DENTAL SCHOOLS	22,435
PUBLIC	13,333
PRIVATE	9,102

DENTAL SCHOOL TUITION

* PUBLIC	$3,324 / $4,264
PRIVATE	$5,939

*Resident/Nonresident

NUMBER OF DENTAL STUDENTS WITH PUBLIC HEALTH SERVICE SCHOLARSHIPS

573

PUBLIC HEALTH SERVICE NEED FOR DENTISTS

2,848

U.S. AREAS WITH NEED FOR DENTISTS

ALL U.S. AREAS	861
URBAN AREAS	137
RURAL AREAS	724

TABLE I

STATE	REGION	DENTAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE TUITION Public (Resident/Nonresident) Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas/ Need Urban Areas Rural Areas
ILLINOIS	V	4 2 2	1726 732 994	$969 / $1,938 $3,478	14	21 / 116 9 12
INDIANA	V	1 1 0	513 513 0	$1,080 / $2,700 NA	3	10 / 49 2 8
IOWA	VII	1 1 0	375 375 0	$1,130 / $2,510 NA	5	19 / 40 1 18
KENTUCKY	IV	2 2 0	566 566 0	$1,200 / $2,500 NA	9	44 / 114 0 44
LOUISIANA	VI	1 1 0	363 363 0	800 / $2,300 NA	4	7 / 34 2 5
MARYLAND	III	1 1 0	523 523 0	$1,750 / $3,550 NA	29	6 / 22 5 1
MASSACHUSETTS	I	3 0 3	716 0 716	NA / NA $6,917	47	4 / 22 4 0

TABLE I

STATE	REGION	DENTAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE TUITION (1) Public (Resident/Nonresident) Private	P.H.S. SCHOLAR-SHIPS	P.H.S. NEED Total Areas/ Need Urban Areas Rural Areas (2)
ALABAMA	IV	1 1 0	294 294 0	$1,200 / $2,400 NA	6	33 / 131 1 32
CALIFORNIA	IX	5 2 3	2106 1217 889	$733 / $2,678 $6,818	58	11 / 123 2 9
COLORADO	VIII	1 1 0	101 101 0	$14,383 / $14,383 NA	5	3 / 6 1 2
CONNECTICUT	I	1 1 0	192 192 0	$1,000 / $2,000 NA	5	3 / 7 2 1
DISTRICT OF COLUMBIA (3)	III	2 0 2	992 0 992	NA / NA $9,900	63	0 / 0 0 0
FLORIDA	IV	1 1 0	249 249 0	$1,800 / $4,068 NA	7	26 / 96 6 20
GEORGIA	IV	2 1 1	649 243 406	$1,135 / $2,310 $5,500	22	65 / 138 5 60

TABLE I

STATE	REGION	DENTAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE TUITION Public (Resident/Nonresident) Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas/ Need Urban Areas Rural Areas
MICHIGAN	V	2 1 1	924 591 333	$2,200 / $4,400 $3,900	13	14 / 80 5 9
MINNESOTA	V	1 1 0	585 585 0	$1,866 / $3,037 NA	4	1 / 3 1 0
MISSISSIPPI	IV	1 1 0	147 147 0	$1.267 / $2,100 NA	3	49 / 121 4 45
MISSOURI	VII	2 1 1	895 640 255	$1,870 / $3,070 $5,750	11	37 / 105 1 36
NEBRASKA	VII	2 1 1	567 260 307	$1,160 / $2,560 $4,900	[illegible]	2 / 3 1 1
NEW JERSEY	II	2 1 1	593 264 329	$4,000 / $5,000 $5,000	7	2 / 7 2 0
NEW YORK	II	4 2 2	1488 459 1029	$3,000 / $4,200 $8,000	29	15 / 145 14 1

TABLE I

STATE	REGION	DENTAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE TUITION Public (Resident/Nonresident) Private	P.H.S. SCHOLARSHIPS	P.H.S. NEED Total Areas/ Need Urban Areas Rural Areas
NORTH CAROLINA	IV	1 1 0	312 312 0	$1,231 / $3,482 NA	13	43 / 188 6 37
OHIO	V	2 1 1	1010 612 398	$1,860 / $3,780 $4,800	10	19 / 71 7 12
OKLAHOMA	VI	1 1 0	279 279 0	$1,200 / $2,794 NA	11	22 / 39 3 19
OREGON	X	1 1 0	312 312 0	$1,123 / $4,500 NA	11	7 / 10 1 6
PENNSYLVANIA	III	3 0 3	1712 0 1712	NA / NA $4,640 / $6,073	60	33 / 199 9 24
SOUTH CAROLINA	IV	1 1 0	169 169 0	$1,400 / $2,800 NA	3	26 / 90 2 24
TENNESSEE	IV	2 1 1	727 533 194	$1,320 / $1,320 $4,000	46	15 / 31 3 12

TABLE I

STATE	REGION	DENTAL SCHOOLS Total Public Private	ENROLLMENT Total Public Private	AVERAGE TUITION Public (Resident/Nonresident) Private	P.H.S. SCHOLAR-SHIPS	P.H.S. NEED Total Areas/ Need Urban Areas Rural Areas
TEXAS	VI	3 3 0	1464 1464 0	$460 / $1,730 NA	17	47 / 224 17 30
VIRGINIA	III	1 1 0	440 440 0	$2,535 / $3,940 NA	19	26 / 80 3 23
WASHINGTON	X	1 1 0	399 399 0	$1,129 / $3,759 NA	14	5 / 10 1 4
WEST VIRGINIA	III	1 1 0	242 242 0	$737 / $2,067 NA	6	33 / 111 4 29
WISCONSIN	V	1 0 1	348 0 348	NA / NA $4,350	2	11 / 23 1 10
PUERTO RICO	II	1 1 0	257 257 0	$500 / NA NA	10	22 / 130 0 22
TOTALS		59 36 23	22,435 13,333 9,102	(4)	373	681 / 2,366 [illegible] [illegible]

TABLE I

NOTES

(1) Public universities usually charge nonresident students more than resident students. Exceptions to this rule are Colorado and Tennessee. Some private universities charge nonresident students more than resident students because they receive a special subsidy from the state. Pennsylvania is such a state.

(2) "Urban" refers to areas within Standard Metropolitan Statistical Areas. "Rural" includes all areas outside of metropolitan areas.

(3) Tuition is based on Georgetown University Dental School. Howard University Dental School receives a special, substantial subsidy which would distort the statistics.

(4) An average of tuition is not presented here as it would be statistically misleading, giving equal weight to a state with one dental school as one with many more. An average tuition for all dental schools is presented in Table III of this Compilation.

TABLE II

STATE & REGION	TOTAL AREAS / NEED URBAN AREAS RURAL AREAS
Alaska X	16 / 17 0 16
American Somoa IX	2 / 4 0 2
Arizona IX	11 / 55 4 7
Arkansas VI	25 / 45 0 25
Delaware III	0 / 0 0 0
Guam IX	0 / 0 0 0
Hawaii IX	2 / 4 1 1
Idaho X	2 / 3 0 2
Kansas VII	20 / 20 1 19
Maine I	3 / 11 0 3
Montana VII	7 / 5 0 7
Nevada IX	12 / 18 4 8
New Hampshire I	0 / 0 0 0
New Mexico VI	16 / 26 2 14
North Dakota VIII	17 / 21 0 17
Rhode Island I	0 / 0 0 0
South Dakota VIII	27 / 26 0 27
Trust Territory IX	2 / 4 0 2

TABLE II

STATE & REGION	TOTAL AREAS / NEED URBAN AREAS RURAL AREAS
Utah VIII	4 / 2 0 4
Vermont I	4 / 7 0 4
Virgin Islands II	1 / 4 0 1
Wyoming VIII	9 / 8 0 9
TOTALS	180 / 280 12 168

STATEMENT OF THE ASSOCIATED MEDICAL SCHOOLS OF NEW YORK ON HEALTH MANPOWER LEGISLATION

Prepared by the Legislative Committee
on Health Manpower

John Fiorillo, Chairman

Stephen H. Lazar, Ed. D.

Barry Stimmel, M. D.

Frank Jones

STATEMENT OF THE ASSOCIATED MEDICAL SCHOOLS OF NEW YORK ON HEALTH MANPOWER LEGISLATION

With the pending expiration of current health manpower legislation in September, 1980, recent months have seen the introduction of several new legislative proposals, including S.2144, introduced by Sen. Richard Schweiker; S.2375, introduced by Sen. Edward Kennedy; S.2378, introduced by Sen. Jacob Javits; H.R.6802, introduced by Rep. Henry Waxman; and H.R.6800, the Administration bill.

The Associated Medical Schools of New York is expressing its position on the proposed legislation. The thirteen institutions represented by AMS comprise ten per cent of the country's medical schools; thus, we feel a special obligation to comment on the potential impact of these bills, particularly on medical education in the State of New York.

Although we are not attempting to respond to every provision in the legislative proposals, we have selected certain key points for comment. This statement addresses issues under the three broad areas of institutional support, student assistance, and foreign medical graduates.

Institutional Support

The issue to be faced here is the basic rationale for federal support of medical education. We concur with the testimony of Dr. Edward J. Stemmler on behalf of the Association of American Medical Colleges in underscoring the importance of institutional support to schools committed to a broad array of educational, research and patient care activities. Tables I through III illustrate the diversity of the educational programs among the 13 medical schools in New York, the steady increase in enrollment despite decreasing federal and state support, and the extent of service provided by those hospitals with affiliations with academic health centers. The last is particularly important because we must consider not simply the impact of the proposed legislation on basic medical education but on the functioning of the academic health center as the hub of an immense network of service. This is of major importance in New York State because of the unusual concentration of large multi-purpose academic health centers here.

If we accept the assumption that medical schools and the health centers of which they are generally a part do, in fact, perform an indispensable public service and that public support is essential to their operation, we must then look at the nature of that public support. With the flexible support that capitation has provided, American medical schools have served as centers for innovation in medical education. The crucial elements in mounting such efforts have been the freedom to innovate and the assurance that government support would be sufficiently stable to allow a school to take on long term commitments to programs. Although we have not had an opportunity to review in detail either H.R.6800 or H.R.6802, none of the legislative proposals appear to take these special needs into account.

As an example, S.2144 uses the current level of special project grants as a base for determining the amount of institutional support. This approach presents two problems: First, as Table IV illustrates, this formula would result in an 86.5 percent reduction in the current level of federal institutional support to the New York medical schools. We acknowledge the motivation to generally reduce federal support; however, a reduction of this magnitude would have a crippling impact on a number of medical schools in the state and severely hinder innovative programming in many, if not all, of these institutions. In fact, this approach could potentially inhibit the kind of programming this legislation aims to encourage. There are greatly varied sources of public and private income for medical schools, including foundation grants, tuition, state subsidies, endowment, university appropriations, and medical practice, as well as federal support. Clearly, special project funding does not, in itself, indicate the full scope of an institution's activities. Thus, to use this indicator by itself to determine the level of federal institutional support could serve as a disincentive to schools to make full use of endowment or other private funds. Since they would not be counted in the formula.

S.2375 appears to provide a better base for calculating institutional support, but there is one serious concern with the approach described in this bill. The proposal provides a medical school with an opportunity to increase its share of support by developing programs and certain characteristics that are viewed as in the national interest. Many of these are relatively short term objectives on which an impact could be made fairly soon. In order to meet these objectives, however, a medical school would have to commit people and funds and, if these objectives should no longer command national attention, the medical school is faced with a programmatic commitment for which there is no longer support.

A fairly recent example of the problem is the commitment many schools made to increasing enrollments in response to the national priority of enlarging the pool of physician manpower. Numbers increased dramatically and swiftly, and now that the federal government has determined that increased numbers of physicians is no longer a top priority, medical schools are left with commitments to faculty and facilities for which there is no longer support. The fact is, medical schools, with their size and complexity, cannot shift quickly from priority to priority. What is required is stable funding that would permit a medical school to make a commitment to a national objective with the security that support will not suddenly be withdrawn, and the school then left with the burden of continuing a program or gradually phasing out with no continuing assistance.

In general, then, the AMS position on institutional support is that stable and discretionary support should be maintained to give medical schools the flexibility required to meet national needs in accordance with their own resources.

In addition to the forgoing general comments, there are three specific amendments to S.2375 which we are suggesting. One of the proposed criteria for determing increased institutional support for a medical school is that more than 50 percent of third year residents are in primary care. Our suggestion is that the definition of primary care include emergency medicine training as well as existing programs. While recognizing that emergency rooms are not appropriate settings for comprehensive, continuous care, nonetheless there is little doubt that emergency medicine is a form of primary care and, thus, such training programs should be included.

The second suggested amendment relates to Section 787 which provides for grants to institutions for programs aimed at increasing minority enrollment. In the current wording, only individual institutions are eligible to apply for funds. An organization such as Associated Medical Schools provides a vehicle for developing programs of common interest among all the medical schools in the State, AMS has a strong interest in the minority issue, and, since this is one area where a consortium approach appears to have considerable potential, we believe such an approach should be encouraged. Therefore, we are suggesting an amendment which would provide positive incentives to medical schools to seek funding as part of such consortia or regional groupings.

Finally, we are also suggesting the uncoupling of the two institutional support criteria under E in Section 772 of S.2375, which are currently presented on an either/or basis. As it now stands, a medical school would have to meet criteria E by either increasing the number of students exposed to such course material as nutrition, geriatrics, rehabilitation, and health care edonomics, or increase the number of students pursuing careers in clinical investigation. We agree that both are highly desirable, but the present wording rewards a school only for doing either one or the other. If the two were made separate criteria, a school would be encouraged to do both.

Student Assistance

We support the broad principles expressed by the AAMC that student assistance must be based on need, that support must be assured throughout the education period; and that debt must be kept to reasonable proportions at least until completion of residency training. We also stress two additional recommendations: 1- That any program of student assistance include provisions for those seeking full time careers in academic medicine, and, 2. that decisions about student assistance be uncoupled from decisions about service in shortage areas.

AMS agrees with the principle that each medical school should develop its own criteria for determining student need. We also believe that medical schools should be able to take a flexible approach to the needs of individual students and establish varying levels of need. Students most in need should not have to pay interest on their loan during the undergraduate medical education years. For these students, interest should also be subsidized to seven percent during residency, following which interest would be paid at the market rate. With a flexible approach, interest subsidies could range from a total interest subsidy for the extremely needy students, to no subsidy at all for those not in need. In order to ensure that a balanced program would exist at each school, one option might be to require that each school stay within an average subsidy rate, which would have to be predetermined.

We are also recommending that need should be defined not only in terms of family income, as it is now, but should also include total indebtedness for education. A student whose family income is at the margin of the needy level might, in fact, be in serious financial need because of a heavy debt load resulting from the cost of education in the undergraduate college years. To maximize a medical school's flexibility in dealing with student financial need, we are also recommending the retention of both the Health Professions Student Loan Program and the Exceptional Financial Need Program. Although the latter has been a small program, it is an important tool for financial aid officers, but again, it should not be limited only to those students who are actually destitute. Its effectiveness would be enhanced by allowing the financial aid office some flexibility in determining the degree of need of an individual student.

The AMS concern about those entering academic medicine stems from the difference in income that can be anticipated in academic medicine compared to private practice. In the approach outlined in S.2144, a needy student might well face the burden of paying back a debt of some $100,000 over the first eight years of a career. This is a particularly acute problem for the young physician oriented to teaching and research as opposed to private practice, and there is a real danger of keeping young talent out of the academic health center for purely financial reasons.

We feel, therefore, that any bill should address the issue of providing incentives for those who would seek careers in academic medicine. None of the bills we have reviewed appear to do this adequately, although, some approaches are suggested in S.2144 and S.2375.

As an example, Section 718 in S.2144 briefly mentions the possibility of continuing an interest subsidy on student loans during time spent in research following training. Because teaching and research are both important in academic medicine, our recommendation is to provide interest subsidies for the early stages of a full time post-training faculty appointment, treating both teaching and research equally.

An example of another approach is contained in S.2375. Proponents of this bill have stated that the intent in S.2375 is to permit the Secretary of H.E.W. to designate an academic health center as an approved site for placement of National Health Service Corps physicians, as a step toward meeting the shortage of academic physicians.

The present wording of the bill does not clearly indicate that possibility nor does it convey a sense of the priority that would be given to meeting this need in such a manner. We feel this is an important concept and thus should be made explicit.

On the issue of service in shortage areas, AMS believes that a student should not have to obligate himself or herself to service as a condition for receiving financial assistance. Student assistance and service represent two different kinds of decisions, and we feel that they should be treated as such in any legislation. However, for those students willing to take on the commitment to service in shortage areas, on completion of their training, we feel that federal loans should be forgiven one year for each year of service, with a two-year minimum.

Along these lines, we also urge the maintenance of the authority for the National Health Service Corps. Although it is not without its flaws, this program has nonetheless filled a serious need in many underserved areas.

Foreign Medical Graduates

This issue is dealt with thoughtfully in S.2379. It has particular importance for the State of New York because of the continuing shortage of physicians in inner city hospitals in the state's large metropolitan areas. AMS generally supports the AAMC position on the FMG issue but differs to some degree on one provision in this bill: The proposed extension of the waiver period for the VQE until 1985. The AAMC has opposed this provision on the grounds that it will simply postpone the time for calling a halt to the waiver period and that we will be faced with the same problem five years from now. AMS acknowledges that the AAMC concern about the quality of care provided in these hospitals is of paramount importance. Recognizing, at the same time, the immediate needs of these hospitals, we are suggesting a compromise position. We recommend that the waiver period be extended through 1983, but that the law require a clearly defined program be developed to utilize that time period to reduce the current dependency on FMGs to fill these positions. This could be accomplished in part through grants to medical schools and affiliated hospitals enabling them to develop innovative ways of using existing technology to meet service needs in a more efficient and effective way. Thus, by 1983, such hospitals would not suffer if this current source of manpower is reduced through elimination of the waiver.

In submitting the forgoing, AMS recognizes the considerable thought that has been devoted to the development of all of these legislative proposals. Our awareness of that effort on the part of the Congressmen, Senators and their staffs made us feel all the more obligated to contribute our own thinking. Time constraints made it difficult to provide more detail than what is contained in this relatively brief statement, and we would be pleased to discuss our position more fully at any time.

TABLE I

NUMBER OF STUDENTS IN TRAINING
1978 - 79
NEW YORK MEDICAL SCHOOLS

Medicine	6,743
Nursing	1,531
Physical Therapy	514
Public Health	399
Occupational Therapy	237
Emergency Medical Paramedics	200
Physician's Assistant	66
Nurse Practitioner/ Nurse Midwife	70

TABLE II

ENROLLMENT IN NEW YORK MEDICAL SCHOOLS

1975 - 1979

		1975-76	1977-78	1978-79
Private Schools	M. D.	4,187	4,480	4,542
State Schools	M. D.	2,059	2,144	2,201

TABLE III

SUMMARY OF DATA ON AFFILIATED HOSPITALS

The number of accredited hospitals in New York State decreased from 416 in 1970 to 383 in 1978-79. The number of affiliated hospitals in the State increased from 52 to 109. In addition, five hospitals out of state became affiliated.

The percent increases in selected data items are shown below:

Registered Hospitals In New York State

	1968 - 69	1978 - 79	% Change
Hospital	416	383	- 8%
Beds	178,922	140,779	-22%
Admissions	2,717,061	2,785,759	+ 2½%
OPD + Emerg.	22,939,193	27,873,314	+21%
Employees	304,632	324,846	+6.6%
Payroll	2,715,281,000	3,998,854,000	+47%
Expenses	4,331,902,000	7,109,943,000	+64%

Affiliated Hospitals

	1968 - 60	% of all hospitals in State	1978 - 79	% of all hospitals in State
Hospitals	52	12.5	109	28.5
Beds	40,000	22	61,639	44
Admissions	729,708	27	1,438,631	52
OPD	4,426,911	20	17,819,787	64
Employees	81,625	26	187,630	58
Payroll	506,000,000	20	2,5[illegible],794,000	63
Expenses	849,983,000	20	4,469,146,000	62

In 1978-79 the twelve medical schools spent 577 million dollars, the faculty numbered 20,700 and non-professional employees 15,500. The affiliated hospitals had 81% of all residents in training in the state.

JED
3-18-80

TABLE IV

IMPACT OF S2144 INSTITUTIONAL AID PROPOSAL ON NEW YORK STATE MEDICAL SCHOOLS

(Thousands of Dollars)

Medical School	FY79 Capitation	FY79 Special Project Awards	20 Percent of Special Project Awards
Albany	556.6	866.1	173.2
Albert Einstein	755.6	1,118.6	223.7
Columbia	650.1	358.0	71.6
Cornell	470.8	326.0	65.2
Mount Sinai	482.7	597.1	119.4
New York Medical	819.7	650.9	130.8
New York University	773.0	---	---
New York: SUNY =			
Buffalo	619.7	287.8	57.6
Downstate	979.6	---	---
Stony Brook	257.7	117.5	23.5
Upstate	608.8	216.0	43.2
Rochester	456.6	471.8	94.4
	7,430.9	5,009.8	1,002.6

The above figures are based on data compiled by the Association of American Medical Colleges

STATEMENT RELATIVE TO THE EXTENSION AND REVISION OF THE PUBLIC SERVICE ACT PERTAINING TO TRAINING FOR THE HEALTH PROFESSIONS AND FOR NURSING

Prepared by*:

George P. Fulton, Assistant Director for Health Affairs, representing the South Carolina Postsecondary Education Commission in the review of Congressional legislation on health manpower in conjunction with the Federal Relations Committee of the State Higher Education Executive Officers (SHEEO)

Please send additional information relating to this subject, responses to the statement, or questions to the following address:

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Columbia, South Carolina 29201

*This statement contains a synthesis of input from the following resources:

Office of Cooperative Health Statistics which is linked to the Office of the Commission on Higher Education in providing the manpower data base for planning for health and medical education

Coordinator for Health Affairs, Commission on Higher Education

Coordinator for Minority Students, Commission on Higher Education

Coordinator for Financial Aid, Commission on Higher Education

Associate Dean of the Medical College at the Medical University of South Carolina in Charleston

Associate Dean of the Medical School at the University of South Carolina in Columbia

A. GENERAL COMMENT

The elimination of construction grants, start-up funding, and capitation grants is probably certain. The national goals upon which these programs were based do not generally apply today. The programs were designated to increase the number of graduates and the Schweiker and Kennedy bills are both in large part based on the forecasts that the supply of health professionals is expected to meet demand by 1990. Therefore, the shift is away from increases in quantity to other national goals (distribution and quality). Nevertheless, we have some concerns over the fact that both bills are based on the expected adequate supply of health professionals by 1990. This does not appear to be holding true in one field at least (nursing). In the past, similar predictions did not hold in the field of engineering.

The shift from support of medical schools through capitation to institutional support with incentives for achievement of national goals is excellent from the perspective of higher education coordinators in South Carolina. We strongly recommend, however, that the federal legislation specify the written approval of state coordinating or governing agencies for higher education as a requirement for the eligibility of medical and health educational institutions to receive incentive grant awards. The purpose of this provision would be to insure coordination at the statewide level and to support projects that respond to statewide needs.

B. STATE-LEVEL PERCEPTIONS FROM THE PERSPECTIVE OF THE HIGHER EDUCATION COORDINATING COMMISSION IN SOUTH CAROLINA CONCERNING THE NEED FOR CONTINUATION AND REVISION OF THE PUBLIC SERVICE ACT

1. Need for State-Level Health Manpower Studies

Planning at the state-level for programs in health and medical education should reflect the need for practitioners, thus requiring a professional staff to collect significant data on health manpower and provide meaningful analyses.

It is our belief that most state higher educational agencies lack staff with training in health statistics and the capability required for this important aspect of program review and planning. In South Carolina we are fortunate in having a state organization with the experience and mandate to do this for the Commission on Higher Education, but the survival of the organization is dependent upon continuing support from the federally-funded National Center for Health Statistics. For such reasons, we urge that careful consideration be given to the authorization of state programs and to provisions for funding statistical research, data collection, and analysis of health manpower needs, through the National Center for Health Statistics and/or by alternative procedures for support of health manpower studies at the state-level.

2. Need for Flexible Funding to Support State-Level Coordination of Financial Assistance to Students, with Requirements for Service in Shortage Areas

We believe that the needs of the State for financial assistance to provide aid for students in the health and medical area are best served by allowing the states to have the flexibility of coordinating federally-provided assistance, state-generated assistance, and community-assistance in a statewide plan. Each state would address problems of maldistribution and shortages through incentives such as tuition forgiveness, reflecting regional needs.

We do not favor the creation of new loan programs for students in the health professions or in nursing, since the existing Guaranteed Loan Program and the National Direct Student Loan Program should be applied to all academic fields and could be revised, if necessary, to achieve the needs of the health professions. As an example, part-time students in nursing and other health professions should be eligible for loans. Provisions should be made to include graduate students in nursing.

Federally insured loans for residents would probably not be in demand in South Carolina because of State support and third party reimbursements.

Bureaucratic regulations would be escalated by establishing new student loan programs as proposed by Senators Schweiker and Kennedy. The Kennedy proposal is complex and could be difficult to administer.

We do not favor "beefing up" the National Health Service Corps as proposed by Senator Kennedy, but instead prefer Senator Schweiker's approach through a new program that would give the states greater flexibility in coordinating the use of federal and local dollars in a concerted effort to solve the problems of distribution of health professionals.

In addition to student loans, federal grants to students (Basic Educational Opportunity Grants) are perceived as necessary to minimize the indebtedness of the student upon graduation and prior to achieving earning power. This is especially important in nursing and allied health.

In South Carolina, the tuition rates at our medical schools are very low and therefore the concern of Senator Schweiker for the high tuition rates in the private sector is not a significant problem in this State.

3. Financial Incentives for Medical Schools to Respond to National Goals

In lieu of capitation funding, we favor the conceptual approach of Senators Kennedy and Schweiker that would substitute basic institutional support for medical schools, coupled with incremental financial incentives for initiatives such as:

Significant improvements in geriatric and gerontological content in the curriculum

Significant improvements in clearly identifiable and relevant nutritional content

Enhancement of genetic concepts and counseling in the curriculum

Significant improvements in preventive concepts and approaches to maintaining health

Enhancement of mental health concepts in the curriculum

Significant attention to behavioral aspects and societal aberrations as causes of illnesses

Development of better understanding and improved relationships among health professions, e.g. physician-nurse, optometry-ophthalmology, physician-physician's assistant, physician-nurse practitioner, dentist-dental assistants

Enhancement of student participation in biomedical research in order to keep the scientific pool of promising young investigators from drying up

Enhancement of the curriculum in non-traditional areas such as ethics, cost-control health care delivery system

We favor augmentation of basic institutional grants in response to innovative programs designed to augment minority students, with incremental financial awards to the institutions in which the programs are successful as measured by an increase in minority graduates. Consideration should be given to programs that enhance counseling awareness of opportunities and preparation at the secondary level.

4. Financial Incentives for Schools of Nursing to Respond to National Goals

In nursing, financial incentives would be very valuable for innovative interventions to correct factors that contribute to the shortage of nursing staff in hospitals. Some of these factors are:

Dissatisfaction of nurses with their pay

Dissatisfaction of nurses with their responsibilities

Dissatisfaction of nurses and physicians with physician-nurse relationships

Physician dissatisfaction with the clinical preparation of new graduates of nursing programs

Some examples of interventions worthy of incentive funding are the following:

Creation of externship programs

Creation of joint appointment with hospitals

Initiation of cooperation of hospitals in teaching, service, and planning

Infusion of additional clinical training in nursing programs

Successes in increasing numbers of minority students

Enhanced participation of physicians on the nursing faculty through seminar participation or lectures

Establishment of programs that facilitate articulation of ADNs and Diploma RNs with BSNs

Creation of programs accessible to school nurses for training in problems of the handicapped child

5. Financial Incentives for Allied Health Programs to Respond to National Goals

In allied health, incentives would be valuable for interdisciplinary programs; for rural practice; and for improvement of educational preparation of faculty through graduate study.

C. SOME FEATURES OF THE KENNEDY DRAFT THAT ARE PERCEIVED AS HAVING SPECIAL MERIT

Title VII - replace capitation by a generic formula for institutional funding, based on the use of the Institute of Medicine Cost Study, (needs up-dating, however) with incorporation of a federal factor to be determined by institutional initiatives in response to incremental financial incentives for achievement of national objectives such as increased minority enrollments, greater participation in primary care and family practice, enhancement of the curriculum in gerontology, nutrition, genetic counciling, and others.

- emphasis on the need to continue to support schools for training of health professionals, not to increase enrollments, but to enhance quality and to strive for national objectives.

- provision of funding to assist with renovation and expansion of teaching facilities for ambulatory care.
- establishment of GMENAC as a statutory council.
- emphasis on counseling in the disadvantaged assistance authorities.
- retention of the area health education center authority.
- proposed new authority for educational initiatives aimed at correcting geographic maldistribution of health care delivery. The statewide plan proposed by Fulton, Syiek, Mayes, and Evans (Journal of Medical Education (in press) could be accommodated under proposed authority.
- new authority for VOPP special projects.
- modification of the general project authority to place greater emphasis on geriatrics, environmental health, nutrition, psychosocial aspects of disease.
- new authority to enhance opportunities for women in health professions.
- new authority to encourage educational research.

Title VIII - replace capitation by institutional funding that would be incremental in proportion to the initiatives taken by nursing programs to respond to financial incentives established for specific national objectives.

- retention of nurse practitioner authority.
- new project authority for expansion or improvement of clinical education for students of nursing.

D. SOME FEATURES OF THE SCHWEIKER BILL THAT ARE PERCEIVED AS HAVING SPECIAL MERIT

The shift away from institutional support (capitation) to student support (loans) must be carefully planned. These programs are very costly and if full aid is not available we, as a society, run the risk of attracting only upper class applicants. We must ensure the entry level of minorities, poor and middle class in a manner which does not result in these students facing an obligation of $30,000 to $100,000 upon graduation.

- general conceptual theme of fiscal restraint, while providing for continuation of financial support for necessary programs.

- recognition of the obligation of students to pay a larger share of the cost of their education in view of the substantial income that will follow completion of their studies.

- use of inducements, rather than regulations, to achieve national goals.

- emphasis on curriculum development and quality.

- discontinuation of capitation grants.

- new program to replace the National Health Service Corps, allowing greater flexibility for the states to resolve their own maldistribution problems.

- incentives for training in primary care, such as loan forgiveness for service.

- incentives for practice in underserved areas.

- provisions for support of health manpower studies as a basis for educational planning.

- provisions for assisting schools of nursing with advanced training, programs for nurse practitioners, curriculum development, educational opportunities for practicing nurses, and continuing education.

- start up assistance only for schools of veterinary medicine, optometry, podiatry, and public health.

- although financial distress grants for medical schools in difficulty are probably necessary, three years should be long enough to correct the problems and improve the management.

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
ALBANY, NEW YORK 12230

DEPUTY COMMISSIONER FOR
HIGHER AND PROFESSIONAL EDUCATION

March 28, 1980

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Through the Federal Relations Committee of the State Higher Education Executive Officers (SHEEO), I have had the opportunity to review your bill relating to financial support for U.S. health professionals and their educational institutions.

I believe that it is nationally accepted that many educational institutions, and perhaps especially medical schools, are facing major financial problems. Growth of endowments has diminished, capital has been invaded, philanthropy has shrunk and operating and construction costs have skyrocketed. Indeed, one medical college in New York recently has barely avoided bankruptcy. Essentially, every medical school has had to turn to tuition as a source of revenue to offset shortfalls in other areas. Certainly from society's point of view, this is an unfortunate happening since it will tend to deny medical education to young men and women whose families are in low or middle income brackets, and will restrict entry to the profession to the wealthy. You can be sure that New York is most anxious to avoid such a situation.

Capitation grants, both federal and state, in the last several years have constituted a very significant fiscal resource for New York's professional schools, especially those in medicine. Without that aid,a restructuring of the schools' fiscal operations would have been necessary and, among other drastic steps, there would likely have been increases in tuition even greater than those that have actually occurred. As you point out, one of the chief reasons for the introduction of the capitation system was to stimulate increased enrollment. There is little question that that has occurred, since the number of students graduating has doubled in the last 15 years. While I would agree that there is less reason to continue this incentive to admit larger numbers of students, it is essential that support be continued, as you would propose to do through your base line system with its incentive and disincentive features, and other special provisions. I am of the opinion that the incentives provided by your measure relating to shortage areas, underprivileged students, family medicine, primary care, practice location, geriatrics and nutrition are meritorious. However, without opportunity to consider further some possible implications of your proposals, I am not certain of their eventual impact on the economic status of our schools. At the least, it appears that there might be some significant accounting problems associated with such a program.

I am pleased to see that your bill includes provisions for assistance to students. There is no doubt that the large debts which students in many of the professions have to accept, combined with high interest rates, discourage capable individuals from entering the professions. They also compel graduates to engage in essentially urban and specialty practices, to the detriment of underserved, rural, and ghetto areas where less remunerative primary care medicine is so much needed. Whether the modifications of the several student loan and assistance programs which you include in your bill will solve many of the problems which now exist is difficult to assess. At the least, the apparent simplification which you envisage appears to be a step in the right direction.

I am very happy to see that you contemplate continuing the National Health Service Corps. This program parallels and complements one in New York State under which the Regents award scholarships to medical students who, in return, agree to practice in underserved areas of the State for a period of nine months for each year during which the scholarship is held. The underserved areas as designated by the Regents, in consultation with the Commissioner of Health, are almost identical with the shortage areas specified by the Department of Health, Education and Welfare. I wholeheartedly agree with you that in the determinations of shortage areas, the proportions of specialty and general practice arrangements need to be taken into account. This does not occur in New York's program at present, but we contemplate taking the necessary steps to bring about this adjustment. Like you, I also believe it would be advantageous in future planning to extend the existence of GMENAC for the foreseeable future, since I am sure that the problems relating to the specialty distribution of America's doctors will need close observation for several years to come.

The bill's provisions regarding project grants deserve support since, for the most part, they tend to aid individuals in entering and remaining in professional education programs, would provide incentives to medical educators for greater concentration in areas such as geriatrics and nutrition which many people feel are not now sufficiently emphasized, would aid women entering the health professions, would aid research in medical education, and would possibly provide additional medical care delivery in underserved areas.

In the sections relating to the training of nurses, I note that there are several provisions which are similar to those called for in medicine. For example, capitation is to disappear, to be replaced with an institutional support program. Should these measures be adopted, deleterious effects on nurse training will occur unless the institutional support program is adequate. In the face of a nationwide shortage of nurses, a capitation program to include incentives for enlarging educational activities such as was used successfully in medicine might be seriously considered.

Though one can possibly accept the elimination of construction funds for new nurse training facilities, it does appear that with the developing educational and research programs in nursing, help in expanding and upgrading existing facilities is vital if the new programs are to succeed.

The provisions in your bill which would aid graduate education for nurses are important and timely, but the phasing out of nurse scholarship programs at the undergraduate level seems questionable from a long range point of view.

Finally, I am in full agreement with the bill's provision which would establish a procedure for the determination of nursing shortage areas such as has been developed for several of the other health professions. In my opinion the delivery of medical care is a team effort in which the nurses play a very significant role and they therefore need to be taken into account in assessing the overall health picture of any given community.

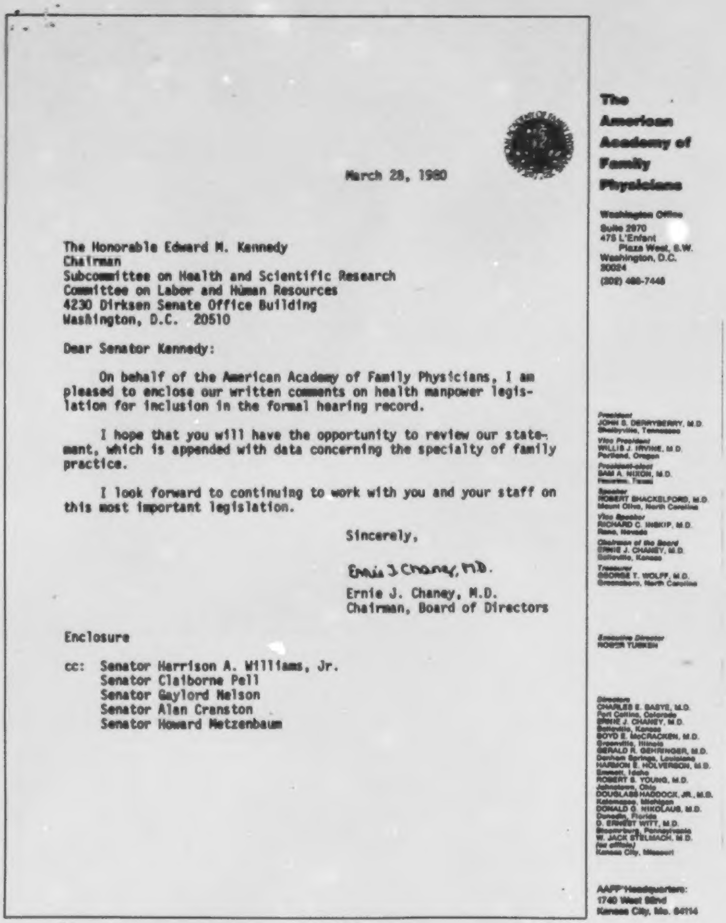
I hope these comments will be helpful in furthering health care plans and I wish to thank you for providing the opportunity to review your proposal and comment on it.

Sincerely,

Dorothy Harrison-Blaney

Dorothy Harrison-Blaney

cc: Senator Jacob Javits



The
American
Academy of
Family
Physicians

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March 28, 1980

The Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and Scientific Research
Committee on Labor and Human Resources
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

On behalf of the American Academy of Family Physicians, I am pleased to enclose our written comments on health manpower legislation for inclusion in the formal hearing record.

I hope that you will have the opportunity to review our statement, which is appended with data concerning the specialty of family practice.

I look forward to continuing to work with you and your staff on this most important legislation.

Sincerely,

Ernie J. Chaney, M.D.

Ernie J. Chaney, M.D.
Chairman, Board of Directors

Enclosure

cc: Senator Harrison A. Williams, Jr.
Senator Claiborne Pell
Senator Gaylord Nelson
Senator Alan Cranston
Senator Howard Metzenbaum

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Kansas City, Mo. 64114

WRITTEN COMMENTS OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS ON HEALTH MANPOWER TRAINING LEGISLATION, SUBMITTED TO THE SENATE LABOR AND HUMAN RESOURCES SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

FAMILY PRACTICE TRAINING SUPPORT

During the last decade, family practice in this country has experienced tremendous growth with the assistance of generous federal financial support, first provided by the Congress in 1972. When the specialty of family practice was officially recognized eleven years ago, there were only 15 approved residency programs where medical school graduates could receive training in family medicine. As shown in the material appearing in Attachment A, by July of 1979, 6,666 family practice residents had completed training and there were 364 residency programs with an enrollment of 6,531 residents.

Not only has this dramatic increase in the number of residency programs had a profound effect in correcting specialty maldistribution, it also has had an effect in correcting geographic maldistribution. Survey data we have collected since 1975 shows that residency program graduates are indeed locating their practices in rural as well as urban areas. As shown in the tables appearing in Attachment B, over 50% of the 1978 graduates entered practice in communities with populations of less than 25,000 and in 1979, 48.8% entered practice in communities of 25,000 or less. Even more illuminating than these figures are figures gathered from a survey of all family practice residency graduates between 1970-1978. Although this survey has not been finalized, preliminary data obtained from the 3,733 residency graduates returning the survey indicates that 53.1% are practicing in a county which has been partly or wholly designated as a health manpower shortage area.

Despite the progress which has been made, much remains to be done to accomplish the objective of establishing enough first-year residency positions to provide graduate training for 25% of medical school graduates. As shown in Attachment C, 83% of all nonfederal physicians involved in patient care in 1931 were family physicians/general practitioners and this percentage has steadily declined to a low of 16.3% in 1978. The physician population identifying itself as being in family or general practice is older in age than the average physician population. Consequently, a somewhat higher attrition rate by death and retirement may be expected from this group than from the general physician population.

In 1979, there were enough first-year family practice residency positions to accommodate 15.9% of all U.S. medical school graduates and we estimate this figure will increase to 16.9% in 1980. To reach the 25% objective by 1982, for example, an additional 1,318 first year residency positions will have to be created. In 1979, approved residency positions had the capacity to accommodate 2,500 residents at the first-year level but received well over 3,000 applications. Thus, last year alone, family practice was unable to accommodate some 500 physicians who might have entered the specialty.

It is the Academy's recommendation that Congress continue the present authorities for support of family practice departments in medical schools (Section 780 of P.L. 94-484) and for the support of family practice residency programs and programs to train teachers of family medicine (Section 786(a) of P.L. 94-484). We are pleased to note that virtually all of the manpower legislation introduced in the Senate and the House renews these authorities while increasing the amounts authorized. We believe the figures we have provided conclusively demonstrate that this money is accomplishing the objective of increasing the number of family physicians being trained in this country, and we are optimistic that an increase in authorizations will work to assure that we not only increase actual numbers but the relative percentage of family physicians as well.

The Academy supports combining the current Sections 780 and 786 authorities in a single authority as has been done in S. 2375. It has been our experience that maintaining two separate authorities has led to confusion in the appropriations process and while we do not recommend changing the substance of the two authorities, we believe combining them would prevent this confusion.

In regard to maintaining the current language, we cannot overemphasize the fact that we believe the current program has been extremely productive and to modify it would be a mistake. One piece of manpower legislation introduced in the Senate--S. 2144--provides that as a condition to the receipt of grant funds, residency programs must be affiliated with a medical school. Some of the best family practice residency programs are in community hospitals not affiliated with medical schools and the Academy is very strongly opposed to this provision. As recent survey of family practice residency programs by an Assistant Dean at the University of Wisconsin--Madison, indicates that the residency programs share our position. Out of 184 programs responding, 161 indicated they had some type of medical school affiliation. However, when asked if they would welcome legislation which would give family practice residency money to medical schools and then let them dispense it to community hospitals, 134 said "no", 17 said "yes" and 3 expressed no opinion.

OPTIONAL MEDICARE AND MEDICAID REIMBURSEMENT

Before briefly discussing other aspects of pending health manpower legislation, we would like to mention one provision in H.R. 6802 which is of particular interest to the Academy in its efforts to promote and strengthen our residency training programs. This provision, contained in Section 501 of Title V of the legislation, would amend Title XVIII of the Social Security Act to provide that residents who are licensed to practice and who are training in general internal medicine, general pediatrics or family medicine may bill on a reasonable charge basis for those outpatient services provided in the primary care training center. Based on discussions with family practice residency program directors, it is our understanding that current Medicare law creates significant difficulties for such programs.

Under present law, medical residents cannot bill Medicare patients for services rendered and salaries for such residents are included as part of the hospital's reasonable costs. This rule does not apply if services are provided off provider premises, in which case services provided by residents are reimbursed on a reasonable charge basis.

Intermediary Letter 372 recognizes there are instances in the teaching setting when the patient is seen by his or her personal physician and sets forth criteria whidh a physician must meet to qualify as an attending physician and bill on a reasonable charge basis. Attending physicians may then bill for services provided by them or by residents under their personal supervision.

While we are not aware that this has created problems in the inpatient setting or for inpatient-based residency programs, it has created a difficult situation for family practice residency programs. The heart of this type of residency training is the model family practice unit which is modeled after the physician's office and provides outpatient services in the same way they would be provided by a physician in private practice. Essential to this training approach is the concept that the family practice resident functions as the personal physician for a defined group of patients. Because they are residents, they cannot bill as would a personal physician but because they are functioning as the personal physician, the teaching physician cannot meet the criteria of an attending physician and bill for those services provided by residents under his supervision.

We believe the Medicare amendment proposed in H.R. 6802 would correct the current problem. At the same time, we are concerned that it not result in creating a situation whereby Medicare would pay both reasonable charges and reasonable costs for the same service. Accordingly, we fully expect that if this amendment becomes law, steps would have to be taked in its implementation to ensure that such double billing does not occur, including promulgation of the requirement that if a hospital elects to adopt this system for services provided in the primary care training center, no part of the salaries paid to residents or teaching physicians for time spent in the center could be included in the hospital's reasonable costs. This is consistent with a recommended experimental payment method in the Institute of Medicine's 1976 Report on Medicare/Medicaid Reimbursement Policies.

GMENAC

We note that both H.R. 6802 and S. 2375 provide for the establishment of the Graduate Medical Education National Advisory Council as a statutory council. The Academy concurs with the authors of these proposals that it is a desirable objective to ensure that knowledgable individuals outside the government have a role in assessing the Nation's health manpower needs on an ongoing basis. The Academy is impressed by what GMENAC has accomplished to date and believes it is appropriate that this body continue to function in the future. Although family practice has been represented on GMENAC, we suggest that consideration be given to statutorily defining its composition to ensure representation by family physicians.

STUDENT ASSISTANCE AND THE NATIONAL HEALTH SERVICE CORPS

Inflation, the ever-increasing cost of tuition and high interest rates on loans have placed an extreme financial burden on medical students, making federal loans essential to many students. The Academy is especially concerned that much of the increase in tuition in recent years has been caused by increased medical school expenditures which are not directly related to the cost of providing medical education. If tuition continues to rise unchecked, no program of student loans will suffice and, for this reason, the Academy believes that in the future, scrutiny must be given to the causes for high tuition fees and further tuition increases.

The Academy supports a plurality of funding sources to enable qualified students with modest means to obtain a medical education. Accordingly, we support continuation of the HEAL program of private loans guaranteed by the federal government and continuation of the exceptional financial need scholarship program.

We recognize there are areas in the United States where young physicians will not voluntarily establish practices because of economics, geography and unavailability of specialty back-up. We believe these areas are better served medically by well-trained National Health Service Corps physicians than by allied personnel and we support the retention of the National Health Service Corps Scholarship Program. We support language eliminating the income equivalence test in order that a National Health Service Corps physician may select the private practice option and we support requiring the Secretary of HEW, before placing a federally paid health professional in an area, to determine that a service obligated physician is not available to enter the area under the private practice option. We believe that adoption of these proposals will improve the likelihood that National Health Service Corps physicians will practice in underserved areas of their choosing and thereby improve the likelihood they will remain in those areas upon completion of their service obligation. We are opposed to a requirement for service obligated professionals to accept Medicare patients on assignment under the private practice option.

One proposal which has been advanced in S. 2375 would create a student loan program whereby students accepting loans would be subject to a national lottery during a specified period of time following graduation from medical school. The number called to service at any given time would depend on the perceived national needs at that time and the loans for those called would be forgiven. The Academy favors student loans as a means of encouraging physicians to voluntarily agree to practice in an underserved area of their choosing, with loan incentives based on the amount of time the physician practices in the area. However, we are opposed to any loan program which would subject loan recipients to a lottery and the uncertainty of being unable to make career decisions until such time as the physician is no longer subject to the lottery. In addition, we suspect this type of proposal would have the unintended result of exacerbating specialty maldistribution problems. That is, it would seem that primary care physicians would be much more likely to be called to service under this type of program and a medical student having to decide between accepting the loan or not going to medical school may logically determine his best option is to accept the loan and enter a subspecialty.

INSTITUTIONAL SUPPORT

Recognizing that capitation support for medical schools may be substantially curtailed if not completely eliminated and recognizing than an absence of some type of federal support may create a financial crisis for medical schools and medical students faced with increased tuition costs, the Academy believes some alternative type of institutional support must be established. We believe it is appropriate to condition institutional support on the attainment of specific goals and, therefore, believe the institutional support program proposed in S.2375 presents such an alternative. Under this program, the capitation amount for any school would be based on the accomplishment of specific objectives with reductions in the amount for achieving undesirable results. Among the objectives of this program which we specifically support are increasing the number of underrepresented minority groups, increasing the number of students entering family practice and primary care and increasing the number of students eventually practicing in underserved areas. We also favor a new authority contain in S.2375 which would authorize grants for long term but time limited support for national priority schools meeting the needs of minority population groups.

SPECIAL PROJECT GRANTS AND CONTRACTS

In addition to the previously discussed special project grants for family practice, we support continuation of the area health education center program and authorities for allied health projects, but believe new roles and types of health workers should be deemphasized. Further, we support proposed special project grants to provide clinical training in remote sites which serve medically underserved populations, to provide support services to physicians practicing in medically underserved areas and to evaluate continuing education and develop innovative approaches to providing such education.

AAFP Reprint No. 150

RESULTS OF ANNUAL SURVEY OF FAMILY PRACTICE RESIDENCY PROGRAMS

August, 1979

I. **Programs:**

A. Total Approval Programs	364
B. Total Operating Programs (9 approved but not operating)	355

Community Hospital Based	57
University Based	62
University Affiliated or Administered	228
Military Hospital Based	17

II. **Residents:**

A. Total Residents	6,531

1. Total First Year Residents	2,360
2. Total Second Year Residents	2,205
3. Total Third Year Residents	1,966

B. Total Approved First-Year Positions	2,500
C. First Year Fill Rate	94.4%

D. Increase/Decrease Class Size by Year

	1977-78	1978-79	1979-80
Class of '80	2,043	1,986	1,966
Class of '81	-----	2,318	2,205
Class of '82	-----	-----	2,360

III. **Residency Graduates:**

A. Total July, 1979 residency graduates	1,724
B. Total graduates from family practice residency programs since January 1, 1970	6,666

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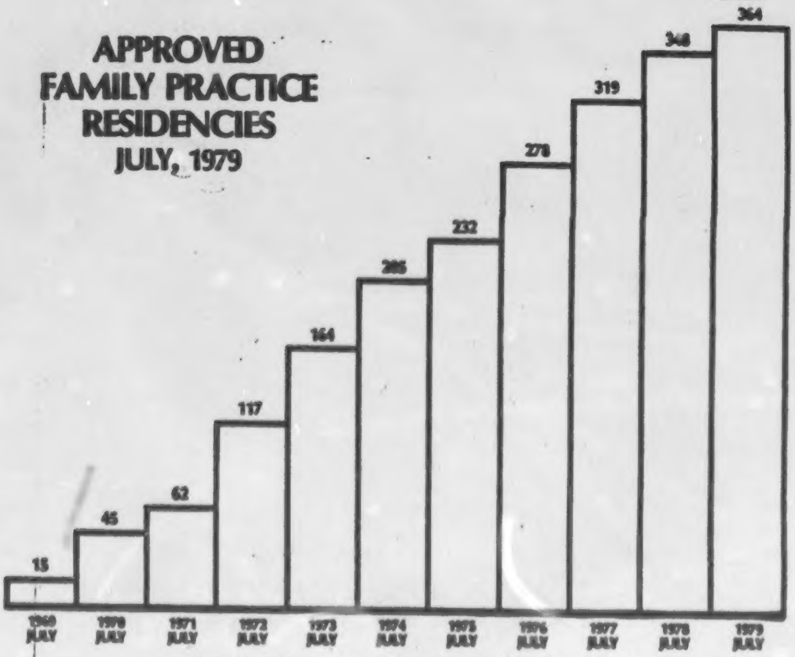
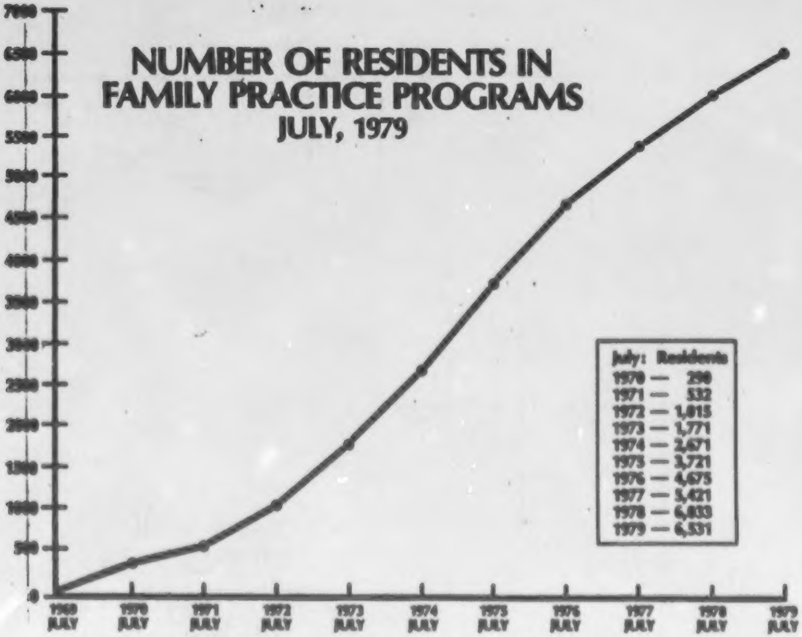
APPROVED FAMILY PRACTICE RESIDENCIES
JULY, 1979



The American Academy of Family Physicians

AAFP 160-B



NUMBER OF RESIDENTS IN FAMILY PRACTICE PROGRAMS
JULY, 1979

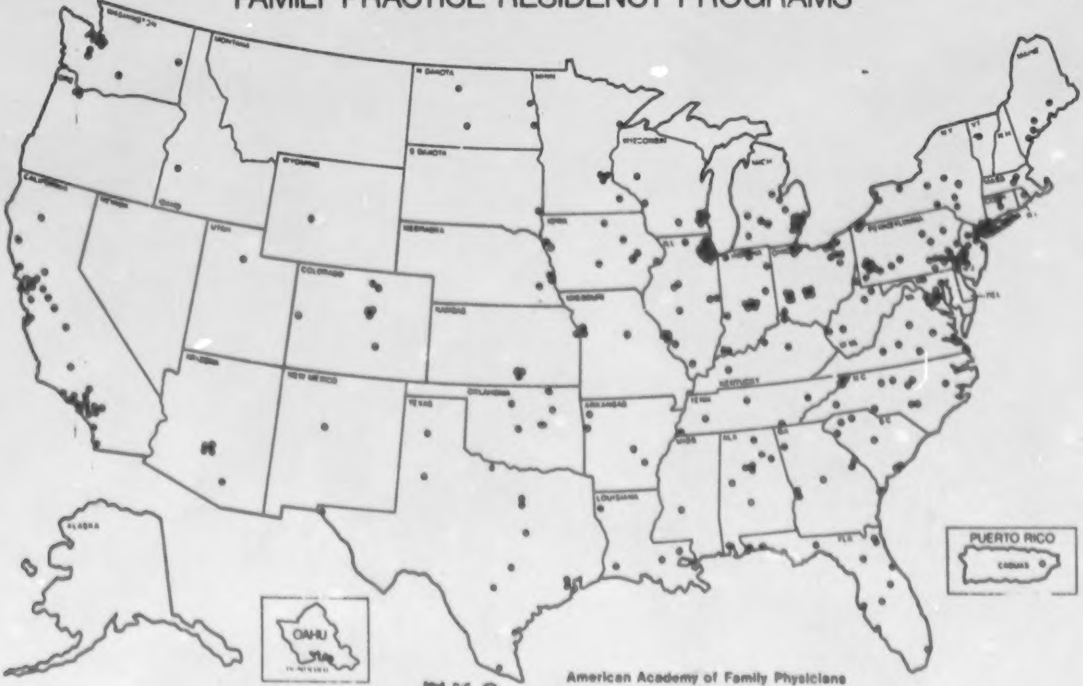
July:	Residents
1970 —	290
1971 —	532
1972 —	1,015
1973 —	1,771
1974 —	2,671
1975 —	3,721
1976 —	4,675
1977 —	5,421
1978 —	6,033
1979 —	6,531

The American Academy of Family Physicians

AAFP 180-C

AAFP # 150A

FAMILY PRACTICE RESIDENCY PROGRAMS


WASHINGTON
MONTANA
N DAKOTA
S DAKOTA
WYOMING
WISCONSIN
MICH
IOWA
NEBRASKA
COLORADO
UTAH
NEVADA
CALIFORNIA
KANSAS
MISSOURI
ARIZONA
NEW MEXICO
OKLAHOMA
ARKANSAS
TEXAS
KENTUCKY
TENN
LOUISIANA
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VT
N H
MAINE
ALASKA
OAHU
PUERTO RICO
CAGUAS

American Academy of Family Physicians

AAFP Reprint No. 155E

American Academy of Family Physicians

REPORT ON SURVEY OF 1979 GRADUATION FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1,724. Of this number, 1,567 (90.9%) responded. Of these respondees, 1,443 indicated type of practice arrangement and 1,345 specified the size of the community which they plan to serve. A summary of the results as of July, 1979, follows.

Caution must be exercised in comparing 1977, 1978 and 1979 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria discribing character and population of communities to which graduating residents were moving to practice. However, 1977-1979 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1979 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	419	29.1%
Multi-Specialty Group	119	8.2%
Two-Person Family Practice Group (Partnership)	261	18.1%
Solo	186	12.9%
Military	159	11.0%
Teaching	68	4.7%
USPHS	104	7.2%
Emergency Room	64	4.4%
Hospital Staff (F-T)	31	2.2%
None of the above	32	2.2%
	1,443	100.0%

DISTRIBUTION OF 1979 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large cities	80	5.9%	5.9%
Rural area or town (less than 2500) within 25 miles of large city	38	2.8%	8.7%
Small town (2500-25,000) not within 25 miles of large city	325	24.2%	32.9%
Small town (2500-25,000) within 25 miles of large city	214	15.9%	48.8%
Small City (25,000-100,000)	213	15.8%	64.6%
Suburb of small metropolitan area	49	3.7%	68.3%
Small metropolitan area (100,000-500,000)	143	10.6%	78.9%
Suburb of large metropolitan area	123	9.2%	88.1%
Large metropolitan area (500,000 or more)	106	7.9%	96.0%
Inner city/low income area (500,000 or more)	54	4.0%	100.0%
	1,345	100.0%	

TGK/cm
7/1/79

AAFP Reprint No. 155D

American Academy of Family Physicians

REPORT ON SURVEY OF 1978 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1,548. Of this number, 1,385 (89.5%) responded. Of these respondees, 1,359 indicated type of practice arrangement and 1,082 specified the size of the community which they plan to serve. A summary of the results as of August 1978, follows.

Caution must be exercised in comparing 1977 and 1978 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria describing character and population of communities to which graduating residents were moving to practice. However, 1978 and 1977 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1978 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	411	30.2%
Multi-Specialty Group	138	10.2%
Two-Person Family Practice Group (Partnership)	262	19.3%
Solo	185	13.6%
Military	130	9.6%
Teaching	70	5.1%
USPHS	61	4.5%
Emergency Room	12	0.9%
Hospital Staff(F-T)	51	3.8%
None of the above	39	2.8%
	1,359	100.0%

DISTRIBUTION OF 1978 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large cities	91	8.4%	8.4%
Rural area or town (less than 2500) within 25 miles of large city	34	3.1%	11.5%
Small town (2500-25,000) not within 25 miles of large city	257	23.8%	35.3%
Small town (2500-25,000) within 25 miles of large city	183	16.9%	52.2%
Small city (25,000-100,000)	186	17.2%	69.4%
Suburb of small metropolitan area	38	3.5%	72.9%
Small metropolitan area (100,000-500,000)	90	8.3%	81.2%
Suburb of large metropolitan area	103	9.5%	90.7%
Large metropolitan area (500,000 or more)	72	6.7%	97.4%
Inner-city/low-income area (500,000 or more)	28	2.6%	100.0%
	1082	100.0%	

TGK/mm
8/1/78

AAFP Reprint No. 420

DISTRIBUTION OF NONFEDERAL PHYSICIANS IN PATIENT CARE* – 1931 through 1978

Year	*Civilian Pop.*	*Total MDs in Patient Care*	*FP/GPs in Patient Care*		*Other Spec. in Patient Care*	
			No.	%	*No.*	%
1931	123,886,000	134,274	112,116	83	22,158	17
1940	131,658,000	142,939	109,272	76	33,667	24
1949	147,578,000	150,417	95,526	64	54,891	36
1960	177,472,000	165,844	74,553	45	91,291	55
1965	192,956,000	239,262	67,510	28	171,752	72
1968 (1)	198,204,000	238,481	56,245	24	182,236	76
1969	200,391,000	247,508	54,508	22	193,000	78
1970	203,046,000	255,027	54,098	21	200,929	79
1971	205,497,000	263,730	52,862	20	211,868	80
1972	207,313,000	269,095	52,330	19	216,865	81
1973	208,950,000	272,850	50,786	18.6	222,064	81.4
1974	210,600,000	278,517	50,935	18.3	227,582	81.7
1975	212,200,000	287,837	51,270	17.8	236,567	82.2
1976	213,800,000	294,730	52,034	17.7	242,676	82.3
1977	213,925,000	315,745	52,062	16.5	263,683	83.5
1978	215,666,000	325,783	53,019	16.3	272,764	83.7

*Figures prior to 1965 were termed "private practice"

(1) Reclassification of physicians in 1968 responsible for drop in "patient care" totals.

Sources: AMA Distribution of Physicians and U.S. Department of Commerce Population Estimates and Projections.

AMERICAN COLLEGE of PREVENTIVE MEDICINE
1015 FIFTEENTH STREET, NW SUITE 403 • WASHINGTON, DC 20005 • (202) 789-0003

AND

Association of
Teachers of
Preventive
Medicine

Statement of the
American College of Preventive Medicine and the
Association of Teachers of Preventive Medicine
regarding
Bills to Extend and Revise
The Health Professions Educational Assistance
Act of 1976

Submitted to the
Subcommittee on Health and Scientific Research
Committee and Labor and Human Resources
United States Senate

March 26, 1980

The American College of Preventive Medicine is one of 22 recognized medical specialty societies composed of over 2,000 physicians. Our members are teachers, researchers, administrators, and practitioners in preventive medicine, a specialty which has four sub areas of board certification: general preventive medicine, public health, occupational medicine, and aerospace medicine. Now in its 27th year, the College was founded to provide a forum for the advancement and dissemination of knowledge in the field. The College is also joined in this statement by the Association of Teachers of Preventive Medicine. The ATPM is a national academic society composed of more than 600 members who are faculty engaged in teaching preventive medicine in the nation's medical schools.

Two of the College's highest priorities are our Prevention Policy and Education programs. The Prevention Policy program, undertaken jointly with the ATPM is responsible for formulating broad national policies for improving the nation's health and the advancement of prevention as a science, while our Education program provides support for undergraduate, graduate, and continuing education for prevention practitioners.

Prevention, though a small field, is dynamic in its concepts and goals. Preventive medicine is the branch of medicine that is primarily concerned with preventing physical, mental and emotional disease and injury, in contrast to treating the sick and injured.

The paramount goal of this area of specialization is to promote and preserve individual health status. Additionally, it is concerned with the well-being of the community, and the efficient and effective management of scarce resources.

The distinct body of knowledge known as preventive medicine can be traced at least to 1913, when the first edition of Rosenau's Preventive Medicine and Hygiene was published. Since that time, the body of knowledge has been extended and its focus has shifted in response to changing patterns in the incidence of disease. For instance, early in this century, preventive medicine was concerned primarily with communicable diseases, while today one major focus is on chronic conditions such as respiratory and heart disease, while another is health maintenance and enhancement.

Training and practice in preventive medicine build upon a diverse, multi-disciplined base. The "core" sciences of preventive medicine include epidemiology, biostatistics, environmental health, nutrition, clinical preventive medicine, the behavioral sciences, management and health care systems analysis.

As noted above, preventive medicine practitioners are engaged in teaching, research, administration, and the delivery of personal health services. Teachers are responsible for instilling an awareness and knowledge of prevention in all medical students, through curriculum developed and taught by departments of preventive and community medicine, or through integrated curriculum in other clinical fields. Non-physician public health personnel are also trained by preventive medicine specialists within both medical and public health school settings. Researchers in the field are engaged in a wide array of activities, ranging from the study of risk factors and distribution of disease (epidemiology) to the design and evaluation of programs to promote health and prevent disease. Physician administrators occupy key positions in public and private settings, such as state and local health departments, and health maintenance organizations, where they are responsible for planning and implementing personal and community health services. Finally, practitioners deliver a variety of prevention services in the community setting, be it the workplace, school, or locality.

In 1979 Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention called for a second public health revolution in the United States. In conducting such a campaign, the importance of prevention and the role of the physician specialist in preventive medicince cannot be overstated. While the incidence of chronic diseases is on the rise, a growing body of knowledge documents our ability to intervene. This knowledge must now be translated into practice. Apart from the avoidance of human suffering, an investment in prevention promises the potential of tremendous returns in human productivity and in terms of cost savings.

PREVENTIVE MEDICINE AND MEDICAL EDUCATION

Our present model of medical education in the United States was largely shaped by a famous report, which included the following among its observations:

> "...The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different perspective and appreciative apparatus to deal with the other, subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physican's horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient - at most to his patient's family; and it was almost altogether remedial. The patient had something the matter with him; the doctor was called in to

> cure it. Payment of a fee ended the transaction. But the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well-being (emphasis added)...[1]
>
> To the intelligent and conscientious physician, a typhoid patient is not only a case, but a warning: his office is equally to heal the sick and to protect the well..."[2]

That was written in 1910, in the "Flexner Report" on Medical Education in the United States and Canada, a report which otherwise revolutioned the course of medical education.

Fifteen years later, in a retrospective study of the 1910 report, Abraham Flexner wrote the following:

> "Curiously enough, despite the increasing importance of preventive medicine, consequent upon the advance of bacteriology and the clearer knowledge of the futility or limitations of many therapeutic measures, hygiene continues to occupy a decidedly subordinate

> position in the undergraduate curriculum; and even incidental treatment of the preventive aspects of disease, though increasingly common, is still far from general."[3]

In 1932 a Commission on Medical Education of the Association of American Medical Colleges (AAMC) made the following observation:

> "Medical education should emphasize to students the influences of urbanization, industrialization, and present day conditions of living which are important in the causation, treatment, and prevention of disease...it is important that the physician be acquainted with the social, economic, and other environmental factors which have an influence on the individual and his health."[4]

In 1945, a Committee of the AAMC, formed to investigate the teaching of preventive medicine and public health in medical schools, again found severe shortcomings in this area. Among other things, the report examined the importance of a distinct department of preventive medicine, as well as the necessity of increasing the proportion of the medical school curriculum devoted to prevention. Committee recommendations, which were approved by the AAMC Executive Committee, included:

"1. That the objective in each medical school be to provide a separate department of preventive medicine and public health and that for purposes of evaluating the organization for teaching preventive medicine and public health in any given school, the combination of preventive medicine and public health with some other department be regarded as unsatisfactory after July 1, 1948...

2. That there be set aside for the teaching schedule of the department of preventive medicine and public health, four percent of the total hours available in the curriculum of undergraduate medical education, and that after July 1, 1948, any medical school providing less that this amount be considered deficient in this regard...

5. That the various departments of the medical school in their respective fields, strive for the greatest practicable contribution in teaching the preventive aspects of disease; that in the highest degree possible, the teaching of preventive medicine and public health be integrated with clinical teaching,

> and that the greater part of the instructional staff in the department of preventive medicine and public health be given hospital and clinic appointments."[5]

In more recent years, both medical school curriculum and residency training in preventive medicine have been the subject of a number of studies. In 1975, a task force on Education and Training of Health Manpower for Prevention (National Conference on Preventive Medicine) found evidence of insufficient training of prevention within medical schools as well as shortages of specialty trained practitioners in the field. The task force recommended that federal health manpower legislation be enacted which would a) encourage a preventive emphasis on the basic curricula for health personnel b) provide career development support for training of teachers of prevention, and c) encourage projects to integrate prevention in programs to train primary health care personnel.

In 1978 these recommendations was confirmed by an Institute of Medicine report entitled A Manpower Policy for Primary Health Care. The report found that "...insufficient attention has been devoted to teaching and research in behavioral and social sciences, to the coordination and continuity of health care, and to clinical experience in outpatient settings." It therefore recommended that

> "Undergraduate medical education should provide students with a knowledge of epidemiology and aspects of behavioral and social sciences relevant to patient care."[6]

Last year the first Surgeon General's Report on Health Promotion and Disease Prevention was issued. In addition to proposing a strategy for the integration of prevention within our health care system, it discussed at length the manpower implications of such a strategy. Again, evidence of future shortages in the field of preventive medicine was cited, as well as an insufficient emphasis on prevention in the training of physicians.

Finally, in December 1979, the Department of Health, Education, and Welfare submitted a report to Congress on community and public health personnel. Among other things, this report contained the following recommendation for action by the Federal government:

> "Encourage and support the development of capabilities to provide training in health promotion, disease prevention, and other public health content in the curriculum of schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, and in schools offering preparation in the allied health programs."[7]

Clearly there has been long-standing consensus that our health care system, particularly the educational system, should place greater emphasis on prevention. This consensus, however, is in stark contrast to current realities:

- Of the nation's 122 medical schools, at last count only 88 have a department of preventive medicine or its equivalent. A number of these are today threatened with closure due to shrinking budgets. Others have already been forced to close down since the last count was made a year ago.

- Federal support for generic special projects in preventive medicine within medical schools has dropped precipitiously, from $1.1 million in FY 79 to zero in FY 80.

- It has been estimated that less than 1.5% of the total undergraduate medical curriculum is devoted to prevention, in contrast to the 4% recommended above by the AAMC.

- Of the 48 active accredited residency programs in preventive medicine, most have only a few funded positions available. For 1978-79, the mean was 4.3 funded positions per program.

- Although it has been estimated that the annual output from these programs which is required to meet needs in the field is 160 graduates per year, currently only 70 complete training annually.

- Federal support for residency training has also declined in recent years. Whereas in 1973 $1.2 million was committed for this purpose, in 1978 and 1979 that level of support dropped to approximately $100,000. In FY 1980 approximately $275,000 will be made available for this purpose.

Although preventive medicine needs have been repeatedly stressed they have seldom been met. The reasons are obviously complex. Chief among these has been the minimal committment of financial resources within medical schools to departments of preventive medicine. Without these resources, existing departments, even where they do exist, are unable to develop the faculty, and hence the curriculum, for long-term impact upon medical student education. Without that impact, new physicians cannot be recruited into the field, further exacerbating faculty development.

When medical students do express an interest in specializing in preventive medicine after graduation, they are faced with uncertain and fluctuating prospects for support during their residency training years. Many residency program directors resort to turning away prospective residents because the resources simply do not exist to support them. Government stipend support is particularly important for the preventive medicine resident because stipends cannot be provided out of patient care revenues as with other "bedded" specialties. An extra year of post-MD academic training is required for board certification. Preventive medicine residents are not hospital based during the remainder of their training, thus program directors cannot offset training expenses by providing services for remuneration. Finally, after graduation preventive medicine specialists generally occupy positions in the public health sector at salary levels which are much less lucrative than private practice, making repayment of educational loans much more onerous.

The current state of affairs has therefore led to extreme shortages in many preventive medicine areas. In addition to impacting on the delivery of public health programs and prevention research, this has obviously had an impact on the status of prevention within the medical school curriculum, thereby completing a vicious cycle. Without the required manpower pool, advancement will be impossible. Certainly if our health care system is to place greater emphasis on prevention, a change must be effected in the attitudes and behavior of medical students and physicians. Federal manpower policy must foster an integration of preventive principles within manpower education. The committment must be made now to develop the necessary manpower base to carry out this mission.

Each of the bills, S. 2144, S. 2375, and S. 2378 contain, to varying degrees, authority for support for departments of preventive medicine and/or residency training in preventive medicine. These authorities will provide a stable base to attract talent and resources into this vital field. At the same time, it is disheartening to note that although the Administration has apparently adopted health promotion and disease prevention as a national priority, it has in its legislative proposal made no provision for development of the manpower base in preventive medicine which will be responsible for designing and implementing programs that respond to that priority.

Although it is encouraging to see that support for residency training in preventive medicine is included in each of these measures, it is vital that the provisions for support of departments of preventive medicine which are contained in S.2375 be included in the final committee bill. Section 793 (a) of S. 2375, which provides support for departments of preventive medicine, would accomplish a number of things. First, it would provide stable, generic support for the activities of the departments which is not tied to a specific purpose. In this way departments will have a resource to draw upon for innovative special projects and activities. Secondly, this section would support vital updating of the curriculum in the core knowledge areas of preventive medicine, because it authorizes projects to strengthen core prevention training programs as well as the preventive medicine interface with the other clinical specialties. Besides being a specialty area of knowledge, prevention also has multidisciplinary aspects which need to be integrated into other clinical specialties. Support for programs to train teachers and researchers, also as authorized in Section 793(a) is particularly crucial. These programs will expand a faculty base which has been drastically reduced in recent years because of diminished investment. Finally, continuing education programs, which are especially important due to the high proportion of med-career entrants into the field, would be supported under this section.

Confronting, as we do, a future of diminished resources which must be allocated among competing demands, it is important that we invest wisely with an eye to future returns. As health care costs have skyrocketed in recent years, alternative forms of cost containment have been examined. None offers more promise that prevention. Clearly, if the goals of our health care system is to assure optimal health at minimal cost, disease prevention holds an important key. The prevention components of bills now pending before the Subcommittee on Health and Scientific

Research will therefore provide the opportunity to unlock and apply knowledge which from as far back as 1910 has been generally recognized as being vital to our nation's health and well-being.

Footnotes

[1] Medical Education in the United States and Canada, The Carnegie Foundation for the Advancement of Teaching, N.Y., N.Y., 1910, p. 26

[2] Ibid., p. 68

[3] Flexner, Abraham, Medical Education: A Comparative Study, MacMillan Co. N.Y., N.Y. 1925, p. 117

[4] Final Report of the Commission on Medical Education, Association of American Medical Colleges, N.Y., N.Y. 1932

[5] Final Report of the Committee on the Teaching of Preventive Medicine and Public Health, Journal of the Association of American Medical Colleges, Vol. 20, 1945

[6] A Manpower Policy for Primary Health Care, Institute of Medicine Washington, D.C. 1978, pp. 77, 101

[7] A Report on Public and Community Health Personnel, U.S. Dept. of Health, Education and Welfare, 1979, p. VII-8

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THE AMERICAN COLLEGE OF PHYSICIANS
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EDITOR

February 27, 1980

The Honorable Edward M. Kennedy
2241 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Kennedy:

The American College of Physicians is very concerned with the development of renewal legislation for the expiring Health Professions Educational Assistance Act of 1976. After reviewing your preliminary staff proposals on health manpower legislation, we prepared the enclosed statement. We are submitting our statement as testimony for the upcoming Senate Human Resources' Health and Scientific Research Subcommittee hearings on S.2144 and other health manpower legislation.

Representatives of the College are also available, if desired, to present verbal testimony before the Subcommittee hearings. If we can be of any further assistance, please do not hesitate to call.

Sincerely,

Robert H Moser
Robert H. Moser, M.D., F.A.C.P.
Executive Vice President

cc: Dr. Robert F. Knouss

Enclosure

RHM/cav

'80
A.C.P.
ANNUAL SESSION
NEW ORLEANS
APRIL 21-24

Statement of the American College of Physicians on Health Manpower Legislation

The American College of Physicians (ACP) is a 49,000-member organization representing a broad spectrum of practitioners of internal medicine, medical educators, clinical investigators and residents and fellows in internal medicine training programs. The College supports the development and implementation of a national health manpower policy predicated on a foundation consisting of detailed analysis of past experience and estimates of future needs. As personal physicians responsible for a large portion of the comprehensive medical care of adults in this country and as educators involved in the training of future physicians, we are particularly concerned with the creation of successor legislation to the expiring Health Professions Educational Assistance Act of 1976 (P.L. 94-484).

The existing comprehensive legislation provides authorizations for numerous federal programs which affect not only the entire spectrum of undergraduate and graduate level health professions education, but also the delivery and availability of health care throughout the country. The Act encompasses programs affecting the construction of health professions schools, student financial assistance, funding for special training programs, the designation of health manpower shortage areas, the National Health Service Corps, assistance for health services research and technology, immigration of foreign medical school graduates, the provision of health care services in underserved areas, and many other programs and special projects.

Each of these diverse programs impinges upon the others; no single program can be adequately evaluated in isolation without considering its overall ramifications. Any renewal legislation will significantly influence the future practice of medicine and the delivery of health care in this country for a period far beyond the actual life of the legislation. The American College of Physicians, therefore, urges a thorough evaluation of existing programs and careful examination of new legislative proposals before enactment of any renewal legislation.

A final report representing the culmination of a four-year effort by the Graduate Medical Education National Advisory Committee (GMENAC) is expected later this year. This report will attempt to project the nation's future health manpower needs, provide evaluations of existing health manpower programs and identify alternative approaches to improve the geographic and specialty distribution of health care professionals. We do not know at this time whether we will endorse the findings or methodology of GMENAC. Time will be needed to understand and evaluate their methodology, to validate their findings and to digest and respond to their recommendations. However, we believe it is important that the findings and recommendations of GMENAC be carefully reviewed and considered in any deliberations concerning national health manpower policy. We do not believe that adequate data are now available upon which definitive conclusions can be drawn.

Medical School Enrollment

The best data currently available, in our judgment, suggest that the overall supply of physicians may exceed the projected need by 1990 and thereby produce a physician surplus. GMENAC estimates that the supply of active practicing physicians will have increased to nearly 600,000 by 1990, an increase of 58% above 1975. Due to the momentum of the health system, most of these physicians will remain in practice for a considerable period of time after 1990. This growth in physician supply will outpace the projected population growth, so that by 1990 there will be 245 physicians for every 100,000 people in the United States. In 1975, the physician-to-population ratio was 177 per 100,000; in 1980 the ratio is estimated to be 197 per 100,000.

In the late 1950's, the Bane Commission issued its report on medical education in the United States; there were 141 physicians per 100,000 population.[1] Recognizing the difficulties in determining the "ideal" number of physicians, the Bane Commission concluded that, since the current (1959) state of the health of the nation appeared to be generally acceptable, maintenance of the ratio of 141 per 100,000 was assumed to be a reasonable national goal.

To assure that this ratio would be sustained, as the nation's population was expected to grow to a projected level of 235 million people by 1975, the Bane Commission recommended a major expansion program for medical education. This was designed to increase the annual medical school output from 7,500 in 1959 to 11,000 by 1975. The numbers of students in existing schools were to be expanded, and 20 new medical schools were proposed. Stimulated by the infusion of federal money from the subsequent Health Professions Educational Assistance Acts of 1963, 1968, 1971 and 1976 plus considerable stimulus from individual state legislatures, medical and other health professions training programs burgeoned. Instead of 20 new medical schools, over 40 have been built. Instead of 11,000 graduates in 1975, there were 12,714. This year, approximately 16,000 new graduates have been projected and the number will continue to expand based on commitments already made. The unanticipated influx of foreign medical graduates (FMGs) to this country, coupled with a decline in the population growth rate, further accounted for the increase in the physician-to-population ratio.

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[1] Physicians for a Growing America -- Report of the Surgeon General's Consultant Group on Medical Education (Frank Bane, Chairman), PHS Publication 709, Washington, USGPO, 1959.

Should the supply of physicians exceed need and produce a surplus, serious consequences may ensue for the American public, the educational community, and the medical profession. There is a significant body of opinion that believes that the aggregate costs of physician activity - clinical examinations, laboratory and other diagnostic tests, prescribed drugs and other therapeutic interventions - could escalate beyond what is needed to ensure optimal health care for the population. Such an expenditure could have a significant adverse impact on the national economy.

Recognizing that the number of physicians is increasing faster than the size of the population, the American College of Physicians recommends that further expansion of current medical school enrollment be stopped.

The possibility of a surplus of physicians should be seriously considered by public policymakers and the academic community. Legislation replacing the Health Professions Educational Assistance Act of 1976 must be sensitive to the current situation regarding health manpower and current projections of a future overall excess of medical personnel. It is also important for all health manpower projections to differentiate clinical investigators and medical educators from full-time medical practitioners. Any such legislation should be sensitive to variations in availability among different types of health care practitioners. The full effects of any legislative actions designed to influence medical education would not be realized until [illegible] or beyond, due not only to the long educational and training [illegible] involved but also due to the extensive time required for educational institutions to plan and implement changes in educational programs.

We submit the following additional remarks in the hopes of being of some assistance to the current health manpower deliberations.

Geographic Distribution

1. The College recognizes that the problems of physician supply are affected by the geographic distribution of practitioners. The effectiveness of the National Health Service Corps (NHSC) in correcting geographic distribution problems should be reexamined in relation to recruitment, placement of assigned physicians and the development of suitably prepared practice sites in underserved areas. The NHSC is a viable pathway for attracting physicians to shortage areas, but it should not be the only pathway. Alternative sources of financial aid outside the NHSC should also be available.

2. Area Health Education Centers (AHECs) and other remote-site education and training programs have proven to be of assistance in correcting geographic maldistribution of physicians. These programs should be supported with due recognition of local and regional needs.

3. The use of financial incentives and other inducements should be further explored by federal policymakers in an effort to encourage the availability of physician services in currently underserved areas. Ample provision for opportunities for professional contacts with colleagues and for continuing medical education activities are important in constructing viable professional arrangements. Adequate and accessible hospital facilities are also factors which may influence physician distribution. Fiscal arrangements alone are unlikely to resolve problems of access to medical care in underserved areas in the absence of measures to address the professional needs of physicians.

Specialty Distribution

1. The College emphasizes both the role of the internist in providing high quality primary care services and the role of the subspecialist in internal medicine in providing significant amounts of similar primary care services. Federal and state financial incentive programs should be expanded to encourage medical schools and teaching hospitals to provide educational programs in primary care fields; this should include internal medicine, pediatrics and family practice.

2. Program directors and institutions responsible for graduate medical educational programs should consider national manpower needs as well as local and regional requirements. This should be a voluntary effort by the medical profession and should consider the issues of need, supply and distribution of physicians and the relation of these items to training programs. The College re-emphasizes the need for an accurate data-base for projected health manpower requirements in order to implement such a program.

3. The College supports the current accreditation efforts of graduate medical educational programs through the Liaison Committee on Graduate Medical Education and its Residency Review Committees in maintaining the educational standards for specialty and subspecialty training.

Medical Education

1. Appropriate and adequate student financial aid programs must be supported at the federal and state levels in order to allow qualified students to enroll in medical school. Financial assistance should be sufficient to allow qualified medical

students to complete their academic and residency training. Repayment provision should be sufficiently lenient so that new physicians are not deterred for financial reasons from engaging in the practice of primary medical care or from establishing practices in medically underserved areas.

2. The College advocates continued federal support for educational programs that assist disadvantaged students.

3. The College urges that funding to medical educational institutions be continued with the following components:

    a. Basic general institutional support to assure maintenance of high educational standards.

    b. Special initiatives to meet specific needs such as geriatric instruction, primary care instruction, nutritional education and basic or clinical research.

Specific Federal Intiatives Due to Expire in 1980:

1. The College supports extension of the following:

    a. Authority to provide assistance to health professions schools which serve predominantly minority students and are in financial distress.

    b. Authority for scholarships for students with exceptional financial needs in their first year of study and grants for recruiting students from disadvantaged backgrounds;

    c. Federal subsidies for Health Education Assistant Loans (HEAL);

    d. Authority for construction of ambulatory primary care teaching facilities.

2. The College supports the following new proposals:

    a. Extension of the repayment period from 10 to 15 years for Health Professions Student Loans (HPSL) and provision to allow each educational institution authority to set criteria for HPSL loan eligibility.

    b. New authorizations for grants and contracts to help professional schools offer training in geriatrics.

    c. Expanded state and federal assistance to support teaching programs that encourage careers in teaching and research.

3. The College sees a continued need for authorization to support training of primary care physicians in internal medicine, pediatrics and family practice.

4. The College notes that physical plants of many medical schools will become outmoded and require new construction over the next few years. Special funding for replacement or remodeling of old buildings and other unusual circumstances should be available on an ad hoc basis in response to need.

Foreign Medical Graduates

1. In light of current projections of physician supply, the College supports the policy of restricting further permanent immigration of foreign medical graduates.

2. The College, recognizing this country's obligation to share its medical knowledge, believes that foreign physicians should not be denied opportunities in this country to obtain the extent of medical training which is in the best interests of the trainee's home country. When requested by a trainee's home government, time in this country sufficient to qualify for American Specialty board certification would seem appropriate.

3. Accordingly, the College supports legislative efforts to amend Section 212 (J) of the Immigration and Nationality Act by substituting a more flexible system for determining the duration of visa status for each FMG on a case-by-case basis. Justification of exceptions should be authorized by the applicant's home country.

4. Preferred status for physicians applying for permanent immigration visas should be available only in the exceptional cases of individuals with unique qualifications who will fill a national need for research or teaching.

Manpower Data Needs

1. The College supports efforts to obtain accurate health manpower data for planning through an effective continous system of data collection.

We recognize that there are many aspects of health manpower policy, and it is difficult for any one organization's statement to embrace them all. The American College of Physicians stands ready to submit further testimony or to otherwise share the expertise of our membership.

/sl

American
Academy of
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50th
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March 20, 1980

Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and Scientific
Research
Committee on Labor and Human Resources
4320 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The American Academy of Pediatrics would like to submit the enclosed statement regarding S. 2144, S. 2375, and S. 2378, the renewal legislation for P.L. 94-484, for inclusion in the hearing record.

Sincerely,

Elizabeth J. Noyes

Elizabeth J. Noyes

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American Academy of Pediatrics

Testimony

on

Health Professions Educational Assistance Act
Renewal Legislation

(S. 2144, S. 2375, S. 2378)

Senate Committee on Labor and Human Resources

Subcommittee on Health and Scientific Research

Division of Government Liaison
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703-525-9560

Mr. Chairman, this testimony is submitted for inclusion in the hearing record on renewal of P.L. 94-484. The policies and concepts contained herein are those of the American Academy of Pediatrics, an international medical association and children's advocate whose more than 22,000 members are dedicated to the well-being of infants, children and adolescents. The comments are derived in part from "The Future of Pediatric Education," August 1978, a report prepared by the Task Force on Pediatric Education, an organization comprised of 10 pediatric societies concerned with the health and welfare of children (see Appendix 1). Several of those organizations have conferred with the Academy on specific points raised in S. 2144 as well. Thus, we believe you will find the Academy's views representative of virtually the entire pediatric community and indicative of the time and effort which we have devoted to the issue of pediatric education and manpower during the past several years.

We submit, Mr. Chairman, that pediatricians now find themselves in a virtually unprecedented position with regard to the changing nature of the practice of pediatrics. Before we elaborate on that statement, allow us to relate it specifically to S. 2144's Section 735, Grants for Training in General Internal Medicine, General Pediatrics and Family Medicine, and point out that the Academy views such grants as both a necessity and a well-conceived approach for dealing with what will be far-reaching changes in pediatrics. If pediatricians, whether they be in practice or in training, are to deal effectively with such changes, a program of financial support independent of medical school resources is a necessity.

To set the stage, allow us to attempt to define what has come to be known as the "new pediatrics." As the pediatric task force which we mentioned earlier conducted its investigations, it became clear that advances in prevention and control of traditional acute and infectious diseases were permitting the pediatrician to devote more time and attention to what had been relatively neglected areas--chronic disease; the increasing number of behavioral problems of childhood and adolescence; and what we call biosocial problems--those health problems socially induced or complicated by social and environmental factors. Because coping with the challenges of modern society will cause an increase in the incidence of biosocial problems, modern pediatric training must be directed more specifically to the treatment of those problems.

The content of experience in biosocial pediatrics should include normal and abnormal growth and development, basic behavioral science information, reactions of children of various ages to illness, education for healthy lifecycles and familiarity with the principal literature regarding child development. Residents should also learn about the nature of psychologic and achievement tests, the principal psychologic therapies, the principles of psychopharmacology, and the techniques of family counseling. They should be familiar with the developmental characteristics of the parent-child interaction, child care practices and dysfunctions in parenting.

Residents should learn to manage such family crises as death and bereavement, suicide attempts, sexual assault, accidents, child abuse, birth of a defective child, separation, divorce, abortion, and a wide range of common behavioral disorders. Furthermore, they should be able to work with the family to resolve problems in parenting, well child care, adoption/foster care, school adjustment, and learning. They should be familiar with the role of the pediatrician in the management of disease states in which psychological elements play an etiologic or contributory role.

There has been also a dramatic increase in our recognition of child health problems associated with poverty, a deteriorating physical environment, changing family structures and other social and psychological factors. There is growing evidence that encouragement of health promotion and changes in lifestyles may become more important than medical intervention in affecting morbidity and mortality. The pediatric community recognizes that pediatric education must respond to these changes in child health needs. We ask Congress to follow suit by authorizing the funds to allow us to develop and maintain an educational program relevant to those needs.

Pediatric programs have, in fact, begun to evidence a shift in emphasis toward treatment of biosocial disorders through a strengthening of ambulatory training. But the shift has been slight, and the bulk of pediatric training still takes place in hospital settings even though the burden of care for children with such problems remains largely in the community. We simply cannot continue to all but ignore the relationship between biosocial and developmental disorders such as early family adjustment difficulties and school failure and the adverse health effects of those problems. A recognition of that relationship mandates pediatric education which emphasizes the processes of human growth and development and their relationship to health and disease.

Because pediatrics is a primary care discipline, and because most pediatric problems are best handled on an outpatient basis, pediatric education should utilize the skills and demonstrate the commitment to personal, continuous care practiced by the general pediatrician. The current preponderance of hospital-based teaching in the pediatric curriculum is one indication of the dissonance between current pediatric education and the health needs of children. By the completion of formal postgraduate training, most pediatricians are extraordinarily skilled at diagnosing and managing illness, especially that of hospitalized children. As a consequence of concentrating pediatric resident education on illness, many if not most pediatric residents have only a rudimentary knowledge of the concept of normality and particularly of the variability surrounding the "average" with regard to child development and health status.

In the future, pediatricians will be called upon more and more to manage children with emotional disturbances, learning disabilities, chronic illnesses and other problems of a developmental, psychological and social nature. They will provide increased amounts of health care to adolescents. They will be expected to manage their practices efficiently, collaborate with other members of the health care team and use community resources to enhance the effectiveness of services to children and their families.

The ambulatory experience resonds to these needs by developing skills in counseling, anticipatory guidance, developmental appraisal, referral, consultation, use of screening procedures and practice management. Skills relating to the care of children with chronic illnesses and handicapping conditions are particularly important. Finally, the ability to coordinate services, plan comprehensive care and mobilize available community resources is essential to provide ambulatory care of high quality. To accomplish all this, there remains a distinct need for faculty development and greater support for research related to ambulatory care. Full-time faculty members in ambulatory pediatrics need formal training in the discipline; it is no longer acceptable to assume that any pediatrician can teach ambulatory pediatrics.

Unfortunately, the pediatric community finds itself in the unenviable position of responding to a dramatic shift in educational need in an atmosphere of fiscal restraint. Moreover, increasingly larger percentages of medical school funds are being devoted to the delivery of patient care, a development which we recognize is a justified response to the public demand for quality health but one which means that other sources of support are necessary if service programs in educational centers are to improve the teaching environment--particularly through the development of model ambulatory care programs. Section 735 of S. 2144 could, with proper direction, respond to this need, and the Academy asks that of the $80,000,000 requested for the fiscal year ending September 30, 1981, $20,000,000 be earmarked for the development of ambulatory pediatric models. This would amount to approximately $156,000 per university pediatric department, an amount in line with grants awarded under existing programs. We would reiterate, also, that the Academy does not seek additional pediatric residency positions but, rather, the means to improve the quality of existing residency training and provide the necessary redirection of content.

The relative availability of funds for research and training in the sixties promoted the growth of subspecialization. The influence of these subspecialities and of the service funds associated with them was an important factor in bringing about emphasis on residency training in inpatient settings at the expense of training in ambulatory care. Traditionally, departments of surgery and medicine, as compared to departments of pediatrics, have received disproportionate levels of hospital and medical school support because of the revenue generated from their hospitalized patients. Lower rates of hospitalization and greater volume of ambulatory care have been contributing factors to under-support of pediatric departments.

The need for federal support of ambulatory training programs derives also from the present pattern of reimbursement for pediatric services by third party payors. The funds used to support pediatric residencies are pooled from many sources including Medicaid, other patient-care revenues, state appropriations and grants. Current reimbursement formulas directly and indirectly detract from the importance of ambulatory care and diminish pediatric department operating budgets by imposing restrictions on full reimbursement for ambulatory care. Medicaid reimburses well below the actual cost of providing ambulatory care in a teaching setting, and many private insurance policies do not cover ambulatory care. Sixty-five per cent of families have no insurance covering office visits to a physician. Furthermore, procedure-dominated reimbursement systems tend to discriminate against the provision of preventive services, which constitute a large proportion of good pediatric practice. Simply stated, pediatric residency programs cannot further expand into ambulatory teaching without independent support. Only separate and dedicated federal funding can accomplish this teaching and training objective.

We believe increased financial support channeled into faculty salaries to be the most effective use of increased funding. Current circumstances find medical school faculty commonly forced to "earn their keep" by delivering medical care during non-teaching hours. This obviously detracts from teaching time and effectiveness. In the pediatric field, this problem is compounded by the generally longer hours required of practicing pediatricians and the above-mentioned disproportionate financial stress on pediatric departments. A more substantial federal support program would free pediatricians on medical school faculties to do their job, namely, to teach pediatrics to the best of their ability.

As the emphasis on teaching ambulatory care increases, pediatric departments will need to cope with the serious shortages of faculty to teach in such areas as adolescent medicine, learning disabilities, care of the chronically ill, ambulatory care, community pediatrics and the behavorial sciences. Faculty development in these areas will require financial support for fellowship and research positions in these disciplines. This means that pediatric education, which is already costly, will grow even more so if it responds to the obvious health needs of our nation's children. In the past we have been much slower to finance ambulatory and preventive care than catastrophic or tertiary care. However, it is increasingly clear that economical and effective health care depends much more on the former than the latter. We ask you to recognize this situation in this and future health manpower funding proposals.

Finally, the American Academy of Pediatrics would like to offer its services to aid in implementing some of the suggestions made above.

TESTIMONY OF

THE AMERICAN ACADEMY OF PHYSICAL MEDICINE & REHABILITATION

Before The

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH & SCIENTIFIC AFFAIRS

Re:

HEALTH MANPOWER

FOR THE RECORD March 26, 1980

Mr. Chairman:

My name is Joseph Honet, and I am President of the American Academy of Physical Medicine & Rehabilitation, a professor of medicine at Wayne State University, and Chairman of the Department of Rehabilitation Medicine at Sinai Hospital of Detroit. The American Academy of Physical Medicine & Rehabilitation is a medical specialty society representing about 1300 physicians who are specialists in physical medicine and rehabilitation. It should be noted that while I represent a medical society and am here to discuss health care programs, the budget items being discussed, rehabilitation, are for the first time in a department other than Health. All rehabilitation programs were transferred to the new Department of Education in the legislation creating that Department.

Need for Physicians Trained in Physical Medicine and Rehabilitation

The shortage of physicians in the field of rehabilitation medicine is well documented. A 1972 study financed by the Commission on Rehabilitation Medicine, "Bulletin No. 14", and subsequently relied upon by the GAO, and the Bureau of Health Manpower and corroborated by the Rehabilitation Services Administration, indicated an average need for 1980 of about 4000 physicians in physical medicine and rehabilitation. Using assumptions requiring a higher but reasonable level of care, 6000 physicians were estimated as necessary. The GAO Report on Physician Distribution by specialty, May 16, 1978, uses two physician-to-population ratios: 1 to 50,000 recommended by the American Academy of Physical Medicine & Rehabilitation and 1 to 77,000 recommended by HEW. These ratios result in need for between 3000 and 4500 physicians in this specialty. This shortage problem was emphasized by this Subcommittee in its report on the FY 1978 and FY 1979 appropriation bill.

Most recently the Commission on Rehabilitation Medicine estimated a long range need for 1990 of 5000 specialists in rehabilitation medicine.

The GAO Report and a 1976 study by the Center for Health Services Research and Development indicate a supply of about 1700 specialists in rehabilitation medicine. Of those, only about two-thirds are board-certified specialists in physical medicine and rehabilitation. The Commission on Rehabilitation Medicine estimates a supply of 2300 for 1990.

"Bulletin # 14" is corroborated by the HEW study "Physician Specialty Maldistribution: 1975". This study frequently mentions physical medicine and rehabilitation as being one of the specialties that is in a shortage situation. The study recognizes that national health insurance will increase demand for physicians in this specialty even more than for physicians in primary care, for example, and that the increase in demand will be substantial if national health insurance is enacted. In general, irrespective of national health insurance, the study indicates a growing interest in rehabilitation which may significantly increase demand. See Chapter 5, page 12.

If there is a reduction in the number of foreign medical graduates trained and practicing in this country, and it appears that there will be, the shortage of specialists in physical medicine and rehabilitation will be exacerbated considerably. The specialty is highly reliant on foreign medical graduates who presently make up close to 69% of all residents.

Further information on the shortage of specialists in this field can be derived from the data of the national physician matching program for purposes of placing interns and residents. On the average, only 30% to 40% of the hospital staff positions being offered for residents or interns in rehabilitation medicine in the past 5 years have been filled. Additional traineeships for residency training in physical medicine and additional support for teaching rehabilitation medicine to undergraduates would assist in filling these positions for which there are not enough applicants now.

The reasons why this shortage in rehabilitation exists are numerous. First, the field is not a glamorous one such as surgery and it is not as remunerative compared to some other medical specialties. Second, in the present educational framework in medical schools, undergraduate students in medical schools are not exposed sufficiently to the field of rehabilitation. Rehabilitation curriculum is not given enough time in undergraduate education, unlike specialties in primary care which are given a substantial amount of time in the undergraduate curricula. Third, many medical schools do not have departments of physical medicine and rehabilitation (about 40 to 50). Many of these medical schools are not patient-oriented but are academically-oriented and, as a result, both undergraduate curricula and, in particular, residency programs reflect the research interests of the institution and of the National Institute of Health. As medical schools become more patient-oriented, it is likely that rehabilitation as well as primary care will receive more attention in the curriculum. Fourth, there are not enough physicians trained in physical emdicine and rehabilitation who can serve as supervisors and educators. Thus, it is difficult to get sufficient exposure to students and it is difficult for hospitals to establish appropriate supervisory programs for the residents which they so badly need in rehabilitation.

The American Academy of Physical Medicine & Rehabilitation believes that a ratio of about one specialist in phyiscal medicine and rehabilitation per 50,000 population represents a reasonably adequate ratio of physicians-to-population. Certainly, we do not feel that this is an ideal or optimal ratio, but it does reflect approximately the best ratio of physicians-to-population in the United States at the present time in a general situation in which there is a drastic shortage and a shortage which affects even a state such as New York with the best supplied population. The New York State ratio was 1.92 physicians per 100,000 population as of 1971. Since that time, demand has increased because funding for rehabilitation services has improved; e.g., Medicare guidelines clarifying rehabilitation coverage were issued only in 1972 and their effects are just being felt within the past few years. Second, demographic data indicates that demand in the future for rehabilitation care will be growing due to the substantially greater proportion of the population who will be aged, for example. Expected broadending of coverage for rehabilitation and Workmen's Compensation law, existing broadening of coverage in state no-fault auto insurance laws, and the expected enactment of some form of national health insurance including catastrophic coverage is likely to increase demands substantially beyond where it is now, not to speak of where it was in 1971. Thus, choosing the ratio of New York State which had the best ratio of physicians-to-population in 1971 seems to be a reasonable figure to pick as a ratio for current adequacy. [illegible]ould be noted that the 1-to-50,000 ratio is underestimated because this is based upon the current predominant method of hospital care practice. Therefore, it does not consider needs which exist in private practice, in supportive nursing home programs and other community involvement by physiatrists.

As indicated above, the American Academy of Physical Medicine & Rehabilitation believes that the enactment of national health insurance will stimulate a substantial increase in the demand for medical rehabilitation services. This fact is borne out by the HEW study referred to above. It assumed that any form of national health insurance will include catastrophic coverage and that medical rehabilitation will be a covered service. Medical rehabilitation is presently a covered service under Medicare but there are substantial limits in the number of days of care covered. The limits in Medicare result from limits on stay which catastrophic coverage would hopefully correct.

I would also like to direct your attention to a policy paper published by the White House on "National Health Care Policies for the Handicapped" which focuses on the shortage of personnel in the rehabilitation field. That paper makes the point that about 20 million people potentially need medical rehabilitation services. That paper recommends increased training funds for rehabilitation medicine. It indicates that "without this kind of educational assistance, physical medicine and rehabilitation, as a specialty, would be seriously jeopardized". It also states that current levels of support are not adequate to attract medical students into this field in increasing numbers.

We are attaching a copy of the study "Bulletin #14" by the Commission on Rehabilitation Medicine for insertion into the record if it is not too lengthy.

Program Needs

Two major problems exist in current medical education which have influenced the shortage phenomenon. First, undergraduate medical education does not adequately provide for training and education in the area of physical medicine and rehabilitation. Thus, few undergraduate students become aware of this field of practice and few physicians understand the problems of managing care for the disabled or chronically ill. Second, too few medical schools have departments of physical medicine and rehabilitation and residency programs. Third, there is not enough financial support for residents to stimulate new entrants to the field. Fourth, there are not enough physicians in this field adequately trained to serve in academic medicine as educators and supervisors.

The Bills Pending

S. 2375 offers positive incentives to medical schools to include substantial education in physical medicine and rehabilitation in the undergraduate curriculum. There is also special project authority to support activities to expand and improve residency training. We hope this money could be used to train more leaders in academic medicine.

S. 2144 has two project authorities to support curriculum development and the establishment or maintenance of residency programs in physical medicine and rehabilitation. There is additional authority in S. 2144 to add funding for special projects in medical schools if among other conditions, which must be met, the school provides undergraduate education in specified areas. Rehabilitation is not included, however.

We thank you for this opportunity to testify.

STATEMENT BY

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PREPARED FOR

THE SENATE HEALTH SUBCOMMITTEE

ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

The American College of Obstetricians and Gynecologists is a professional organization representing over 20,000 physicians providing reproductive health services and health care to women. As such, the ACOG recognizes the need for and assumes responsibility for collecting and maintaining current data with regard to obstetrics and gynecology including studies identifying practice patterns of physicians in the specialty and practice preference of medical students and residents in obstetrics and gynecology.

In part supported by the Department of Health and Human Services (under Grant #MC-R-170397) the ACOG initiated a two year project in 1977 entitled, Manpower Planning in Obstetrics and Gynecology. Grant funding has been extended an additional 2 years which will provide extensive information on the future supply and practice responsibilities of physicians and allied health professionals specializing in women's health.

As you are aware, the Graduate Medical Education National Advisory Committee (GMENAC) has been working for some time to project supply needs in 1990 for physicians across all specialties. ACOG has participated in the GMENAC effort and has contributed input in attempts to assure that the report of this Committee to Congress reflects an accurate representation of the practice of obstetrics and gynecology. Our work over the past several years compiles and documents information which we believe will be helpful to Congress as it begins its review of the Health Professionals Education Assistance Act. We gladly offer the benefit of our research, our cooperation, and any assistance from the ACOG that the Subcommittee on Health and Scientific Research may find helpful.

During the years 1974 to 1976 when the HPEAA was last discussed in Congress, the Senate concluded its debate holding that the federal government should continue to play a role in assisting institutions to train students going into the health professions. Wisely, Congress reasoned that funding support to institutions providing medical education should move away from increasing the aggregate number of physicians and toward achieving national objectives identified as improved distribution of physicians by specialty and geography. Legislation in Congress proposed to link capitation support and institutional support to programs which encouraged physician training and service in underserved areas. The House and Senate concurred that these priorities were essential to any federal policy developed with regard to health manpower.

Substantial debate and discussion surrounded agreement in identifying the specialties which would be recognized by government as primary care specialties. On this point, the House of Representatives and Senate held different positions. The House of Representatives clearly determined that obstetrics and gynecology would be among those specialties classified as primary care. In its Committee Report to accompany HR. 5546 (Rept. No. 94-266), members of the House Committee on Interstate and Foreign Commerce proposed that there be established "a limitation on the number of medical residency positions in the United States .... Included in that provision is a requirement that, in designating medical residency programs that may be available in the United States, particular attention should be offered to the need for medical residency training in primary care specialties of general internal medicine, general pediatrics, family medicine, and obstetrics and gynecology." (page 43)

As this legislation moved toward enactment, the provision taken by the House acknowledging and supporting obstetrics and gynecology as a primary care specialty was lost in Conference. As implemented, P.L. 94-484 excludes obstetrics and gynecology residencies from support as training primary care physicians.

The American College of Obstetricians and Gynecologists would like to take this opportunity to illustrate several points which we feel counter present policy and which we feel provide a significant argument in favor of recognition of obstetrics and gynecology as a primary care specialty in the HPEAA reauthorization legislation. We ask the Subcommittee to reconsider this issue in light of the following and to adopt a position to include obstetric/gynecologic residencies with other primary care residencies during the reauthorization process.

Support for this position is reflected in the following:

.... Health Manpower Reserach funded by DHHS and conducted by Mendenhall at the University of Southern California examined practice patterns across all specialties. Applying the same definitions to all specialties, Mendenhall found that 78% of patient encounters with obstetrician/gynecologists can be classified as of a primary care nature. Contrast this finding with Mendenhall's report on general internal medicine where 73% of patient encounters were found to be of a primary care nature. Additionally, Mendenhall found that every day in the United States general internists see 293,000 women; obstetricians and gynecologists see 309,000 women.

.... Agreement has been reached on this issue within the private

SECTOR WHICH CLASSIFIES OBSTETRICS AND GYNECOLOGY ALONG WITH PEDIATRICS, GENERAL INTERNAL MEDICINE, AND FAMILY PRACTICE AS A PRIMARY CARE SPECIALTY. THE COORDINATING COUNCIL ON MEDICAL EDUCATION, A PARENT ORGANIZATION WHOSE MEMBERS INCLUDE THE AMERICAN MEDICAL ASSOCIATION, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE AMERICAN HOSPITAL ASSOCIATION, THE AMERICAN BOARD OF MEDICAL SPECIALTIES, AND THE COUNCIL OF MEDICAL SPECIALTY SOCIETIES, RECOGNIZES THIS DESIGNATION.

.... EVEN THOUGH RESIDENCY PROGRAMS IN OBSTETRICS AND GYNECOLOGY ARE OMITTED FROM THE HPEAA'S PRIMARY CARE DEFINITION AND THEREFORE DO NOT RECEIVE PRIORITY FUNDING, RESIDENCY PROGRAMS IN OBSTETRICS/GYNECOLOGY ARE INCLUDED UNDER THAT ACT ALONG WITH THE RECOGNIZED PRIMARY CARE SPECIALTIES AND ARE REQUIRED TO PROVIDE THE SAME SHARED RESIDENCY OPPORTUNITIES. THE BUREAU OF HEALTH MANPOWER, DHHS, INCLUDES OBSTETRICS/GYNECOLOGY AS WELL AS RECOGNIZED PRIMARY CARE SPECIALTIES FOR PURPOSES OF IDENTIFYING HEALTH MANPOWER SHORTAGE AREAS. IN LINE WITH THIS POLICY, THE NATIONAL HEALTH SERVICE CORP ACTIVELY SEEKS AND RECRUITS MEDICAL STUDENTS WHO HAVE DEMONSTRATED INTEREST IN PURSUING A RESIDENCY IN OBSTETRICS AND GYNECOLOGY AND WHO WOULD EVENTUALLY FULFILL THEIR SERVICE OBLIGATION IN HEALTH MANPOWER SHORTAGE AREAS.

WE FEEL THAT DHHS POLICY AND IMPLEMENTATION OF THAT POLICY HAS CLEARLY DEMONSTRATED A PRIORITY NEED FOR TRAINING OBSTETRICIANS/GYNECOLOGISTS. WITH THIS IN MIND, PRESENT HPEAA AUTHORITY WHICH OMITS OBSTETRICS AND GYNECOLOGY RESIDENCIES FROM SPECIAL TRAINING FUNDS IS IN CONFLICT WITH THE NEED IDENTIFIED BY DHHS. ADDITIONALLY, WE FEEL THAT RESEARCH HAS DEMONSTRATED THE HIGH DEGREE OF PRIMARY CARE WHICH IS ACTUALLY PROVIDED BY THE OBSTETRICIAN AND GYNECOLIGIST IN PRACTICE.

Again, we request that the Subcommittee consider the merits of the research and the persuasiveness of information which has become available since enactment of P.L. 94-434. By so doing, we are hopeful that the policy contained within the Act with respect to obstetrics/gynecology residencies can be revised during the reauthorization process.

American Psychiatric Association
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Statement of

The American Psychiatric Association
and
The American Academy of Child Psychiatry

on

The Health Professions Educational Assistance
and Nurse Training Act of 1980
(S. 2144)

and

The Health Professions Training and Distribution
Act of 1980
(S. 2375)

and

The Health Care Management and Health Care
Personnel Distribution Improvement Act of 1980
(S. 2378)

March 25, 1980

The American Psychiatric Association (APA), a medical specialty society representing over 25,000 psychiatrists nationwide, and the American Academy of Child Psychiatry (AACP), representing 2,300 psychiatrists who have completed two years of additional training in child psychiatry, submit the following statement in regard to consideration of Federal health manpower legislation by the Subcommittee on Health and Scientific Research of the Labor and Human Resources Committee of the United States Senate.*

At the outset, the APA wishes to express its strong support for the provisions of Senator Kennedy's bill, S.2375, which recognizes the critical need to designate psychiatry as a medical shortage specialty. Such provision reaffirms the integrity of the legislative process. It ensures that S.2375 "tracks" the Congressional findings of S. 1177, the Mental Health Systems Act, which also provides that psychiatry is a medical shortage specialty. We believe such recognition will encourage more individuals to select psychiatry as a career and provides the needed psychological reinforcement to demonstrate both concern and reality.

The statement will focus upon the scope and dimensions of America's mental illness problem and what the APA believes should be the response to those problems through Federal health manpower legislation. The statement will also provide further support for the above-cited legislative determination that psychiatry is a medical shortage specialty.

There are as many as 20 to 32 million citizens of this country identified by the President's Commission on Mental Health identified as in need of treatment for mental illness. We are speaking of two million individuals who have been or would be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. More than 25 percent of those elderly persons diagnosed as "senile" actually have a diagnosable, and if treatable, reversible, mental disorder, and need not be forgotten, or written off by society as lost. The number of children in need of immediate psychiatric intervention is conservatively estimated by the AACP at 5 million.

Yet, the evidence with respect to the numbers of psychiatrists available to provide medical/psychiatric care for these millions of Americans, emphasizes that there is a serious shortage. For example, the FY 1980 Sentate Appropriations Committee Report expressed the following concern:

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*Whenever "APA" is mentioned, such mention is intended to include the AACP.

> "The Committee continues to be concerned about shortages of trained psychiatrists, psychologists, psychiatric social workers and psychiatric nurses. The shortfall in personnel across the four core disciplines is most severe for psychiatry because of a rising utilization rate and a decline in the supply of both United States and foreign medical graduates in the field of psychiatry. Figures provided the Committee show that in fiscal 1980 alone there will be a shortfall of 10,000 psychiatrists and that this shortfall will increase further in the 1980s."

The FY 1981 House and Senate Labor-HEW Appropriations Subcommittee in ADAMHA hearings again expressed concern about the shortage and implored the Administration to explain how the needs of the mentally ill can be met with a static training budget. The Administration response indicated shortage estimates for psychiatrists ranged from 10,000 to 60,000.

In the exchange between members of Congress and representatives of ADAMHA, NIMH and Secretary Harris' office regarding GY 1981 clinical manpower training funds, the response really was not whether there is a shortage, but how large it is.

A factor which had an impact on this shortage was the implementation of P.L. 94-484 which reduced the number of FMGs who could train and remain in this country. Many of these FMGs trained as psychiatrists. The APA believes that this country has the responsibility to meet its own psychiatric needs with qualified physicians and that it should not endorse or maintain policies which create a "brain drain" on foreign countries.

Further, we suggest that this nation's medical education policies should not emphasize or enhance the attractiveness of one shortage specialty, such as primary care, without analyzing the impact this emphasis will have on another shortage specialty, such as psychiatry. We endorse the support given primary care for, as you know, at least 35 percent of mental conditions are first detected by primary care physicians, but liaison psychiatry is an important concept which the pending legislation needs to develop further. Liaison psychiatry programs and activities for nonpsychiatric physicians (primary care and other medical specialties) provide education, training and assistance to such physicians by psychiatrists in the biopsychosocial aspects of medical care using the existing medical setting and patient. What is needed, however, is an equivalent commitment to recruit, train and place adequate numbers of psychiatrists to meet the varied needs and goals articulated in the President's Commission on Mental Health, its implementing task forces, and the shortage, estimated by GMENAC and acknowledgod by NIMH. It will take interagency cooperation among ADAMHA, HRA, HSA, HUD, VA, DoD and others, to address this problem comprehensively.

A study of expressions of career preference among individuals who took the 1977-78 Medical College Admission Test (MCAT) was shown to reflect actual career choice. There was a 28 percent drop from 1976-77 to 1977-78 in individuals expressing a preference for psychiatry. Of the pool of applicants, only those expressing a preference in family medicine increased (from 25 percent to 35 percent in the same one-year period). The 1976 health manpower law, P.L. 94-484, was signed October 12, 1976, and the new provisions took effect October 1, 1977. This law strongly expressed Congressional recognition of the shortage of primary care physicians. Such statutory recognition had an instantaneous impact on those students who were deciding on becoming physicians. Likewise, with no concomitant expression about psychiatry, the opposite result occurred, despite data on need and utilization and projections relating to reductions in psychiatric FMGs.

While the law did create the opportunity for criteria for the designation of psychiatric manpower shortage areas under Section 332, and it was estimated that by the end of 1979, 1,200 psychiatric shortage areas would be designated pursuant to such criteria, currently there are only approximately 160 designated psychiatric shortage areas and there are only 13 psychiatrists in the National Health Service Corps.

Only late last year did the Health Resources Administration (HRA) amend the scholarship program selection criteria to give students interested in psychiatry "category one" preference (equal to that for primary care) for scholarship selection. Also noteworthy is the deplorable and inexcusable paucity of mention of the training needs of psychiatrists and the service needs for such psychiatrists in the recently released HRA publication, "Report on Health Personnel in the United States." For instance, even though there were specific designation criteria for psychiatry published in the January 10, 1978 *Federal Register*, the HRA publication does not either in a table or in the narrative discuss the number of psychiatric health manpower shortage areas or psychiatrists needed as of October 31, 1978, despite the fact that every other type of shortage area was displayed in the table. We note from this report that as many as one-eighth of our population resides in medically underserved areas. Moreover, the report further indicates that increasing emphasis should be placed on the needs of a population which is growing older and fraught with increasing numbers of chronic conditions. This is a population with significantly greater mental health needs. We note that the report does not raise similar concerns with respect to the mental health problems confronting our nation's population, including children and adolescents.

Congressional deliberations on the renewal of the Nurse Training Act, resulted in the law being amended to delete the three-year maximum deferment a physician could receive before he or she would be required to perform obligated service in the National Health Service Corps or Indian Health Service. Since psychiatric residencies are at least four years in length, the three-year limit clearly discriminated against psychiatric residents--not to mention psychiatric needs of the NHSC, PHS and IHS. The APA is gratified that this provision will be retained and recommends that it be authorized for other programs such as the Health Education Assistance Loan (HEAL) program.

Also, we would recommend that medical students who are preparing to become primary care physicians should receive substantial training in the bio-psychosocial aspects of care. They then would have sufficient ability to diagnose, treat and refer, when appropriate, for mental illness. In 1976, it was estimated that 43.4 percent of persons diagnosed as having a mental disorder are treated in the general medical sector. There is a demonstrated need, therefore, for strong liaison prychiatry education in medical schools and in general residency training programs to ensure that primary care physicians will have the most appropriate tools to recognize, treat, or refer, when appropriate, those patients with mental disorders which are masked by or accompanied with physical symptoms. We would encourage the statutory inclusion of biopsychosocial aspects of medical patient care in all primary care training sections.

Further, Section 788(d) of current law contains authority to fund health manpower projects and programs such as "cooperative human behavior and psychiatry in medical and dental education and practice" (Section 788(d)(4)) and "training in the diagnosis, treatment and prevention of the diseases and related medical and behavioral problems of the aged" (Section 788(d)(21)). These programs, because of the potential they offer to address the joint presentation of physical and mental illness, should be retained. We have already discussed the essential nature of liaison psychiatry. With reference to the aged, the President's Commission on Mental Health, among other entities, has cited the cost-effectiveness of providing mental illness coverage for the aged. Therefore, training in geriatric psychiatry also would be cost effective.

With respect to provisions regarding reimbursement policies, the APA is supportive of Title V of H.R. 6802 which would revise Medicare and Medicaid reimbursement policies relating to primary care residency programs. However, we would recommend that such Title should be amended to include psychiatric residency programs and psychiatric outpatient/ambulatory care facilities, particularly because psychiatry is not a technology-oriented specialty, but a time-based specialty and has increasingly emphasized ambulatory care, prevention, and early intervention. We would welcome the opportunity to provide you with any additional information that you may require to support our suggested amendment to revise reimbursement policies for psychiatric residency programs.

Other APA specific amendments to S. 2144, S. 2375 and S. 2378 we submit for your consideration follow.

With respect to the Service Contingent Loan Program, as proposed in S.2375, the APA has serious reservations about the effect such program will have on the obligation of physicians who plan to enter practice in a shortage specialty, such as psychiatry, for which there are designation criteria and for which health manpower shortage areas have been designated. While we believe that the purposes of this program are laudable (it is designed to assist a greater number of persons than does the Health Professions Student Loan Program), we are concerned that the implementation of this program will be most inequitable. The service contingent obligation "window" will, of necessity, open upon those physician specialists in greatest need, e.g., psychiatrists, while other specialists will not be needed to provide service. Thus, what appears to be a random lottery will, in fact, be most unfair to medical shortage specialties.

The data previously referred to in this statement indicate there is shortage of psychiatrists ranging from 10,000 to 60,000. If more scholarships under the National Health Service Corps Scholarship Program are not awarded to medical students interested in going into psychiatry in proportion to the number of shortage areas ultimately designated under Section 332 of the Public Health Service Act, psychiatrists will have the most exposure to service obligation under the service contingent loan program. The "loan" program, then, would be in reality an obligated service contract with a far different repayment provision than is provided under the NHSC scholarship program and will discourage students from choosing careers in shortage specialties (such as primary care and psychiatry). Such a result is directly contrary to the purposes we believe the overall legislation is designed to foster.

We are concerned that Section 747(e)(2) of S. 2375, does not accord the same deferment status to the medical shortage specialties of psychiatry and child psychiatry, which require four and five year residencies, respectively, as accorded to residency programs that can be completed in three years. In order to encourage students to choose careers in underrepresented specialties, there must not be explicit or implicit disincentives. In addition, the bill does not establish a date by which the Secretary is required to notify students whether they have been chosen for service and the location of such service. We would anticipate fewer participants in this program unless clear deadlines and procedures are mandated by regulation or statute.

The Federally Guaranteed Loan Program for Needy Students proposed by S.2144, which would replace the HPSL program appears to offer an attractive approach to financing the education of "needy" students utilizing the private market. We would make the same recommendation we made earlier regarding deferment of repayment of principal and interest to encompass the duration of the internship and/or residency periods for psychiatry and child psychiatry. We would hope the definition of "need" will be responsive to the needed mix of minorities and reflect the chaotic changes in the money market as related to financial need. We are concerned whether the funds recaptured by the dissolution of the HPSL program would be sufficient to support the forgiveness and shortage area service features supported by other provisions of S.2144.

The APA is pleased by S. 2375's amendment for the Health Education Assistance Loan (HEAL) program, but recommends that the four year program deferral provisions (instead of the current three) be extended appropriately and not continue to discriminate against individuals seeking to become child psychiatrists, a five year residency program. Recent data indicate that there is a severe shortage of child psychiatrists. The present production of 300 child psychiatrists yearly is barely adequate to maintain the current force of 3,000 child psychiatrists, and does not address any of the problems of shortage, which GMENAC is expected to project at 30,000.

We therefore would recommend that Section 731(a)(2)(C) of S.2375 make provision for residencies extending beyond four years which train individuals in specialties and subspecialties determined by the Secretary to be in short supply. The APA also believes that an NHSC and Armed Forces Scholarship recipient should not be excluded from obtaining HEAL program funds, as proposed in S. 2375, because there may be circumstances which would make these additional funds essential for a student to continue to pursue a health professions education.

S. 2144 establishes the Federally Guaranteed Loan Program in lieu of the HEAL program. We are concerned that this program contains discriminatory provisions, previously discussed, relating to the deferment of principal and interest for individuals receiving internship and/or residency training. Congress acknowledged the need to reverse the adverse impact of the three year limitation for shortage medical specialties (P.L. 96-76) and provide opportunity for individuals to have complete residency training in general psychiatry and child psychiatry prior to having an obligation to service. We recommend that Sections 716(b)(4) and 718(c)(1)(C) of S. 2144 be amended accordingly and make provision for general psychiatry and child psychiatry, both of which are specialties with severe shortages and require respectively four and five years to complete residency training.

We endorse the modifications proposed in S. 2375 relating to the First Year Scholarship Program for the Exceptionally Financially Needy (EFN), including the change in the amount of the scholarship. We would hope that more students would be able to benefit from the program. Further, we would endorse the expansion of this program to a two-year program, and would also like to see the current definition of EFN revised so that a larger number of "needy" students could be included.

The National Health Service Corps (NHSC) Scholarship Program is proposed to be modified by both S. 2144 and S. 2375. S. 2144 would phase down the NHSC Scholarship Program to one-third of its FY 1980 level over a two-year period and would establish a new state service-conditional scholarship program funded by the funds which otherwise would have been obligated to the NHSC Scholarship Program. The program of Federal basic and matching grants to states to support scholarships to individuals who agree to practice in a shortage area is a laudable attempt to shift the emphasis of Corps service to the states, but we question whether such concept will work in practice. We believe more study must be given to whether states will be willing to assume the responsibility of supporting scholarship recipients' salaries in an amount "not less than the comparable salary of entry level individuals employed by the United States who possess a similar educational background."

The APA would request further amendments to Section 751(d) to provide that medical scholarship awards be awarded proportionately to the needs for physician specialists in proportion to the severity of shortage of medical specialties. And, that if the current distribution of scholarship awards is less than that need, that an increased percentage be awarded to these shortage specialties until a reasonable balance occurs.

The APA supports the concept of the private practice option and is pleased that both S. 2144 and S. 2375 address this concept. We believe that the additional incentives proposed by S. 2375 will be beneficial in enhancing the attractiveness of the private practice/independent practice option and in meeting long term needs of this Nation. We also believe that the authorization levels for the NHSC Program are inadequate and do not incorporate inflation or nominal growth factors. Other recommendations for the NHSC Scholarship Program, which are not specifically addressed in the proposed bills, are as follows:

Section 332(d) (relating to designation of health manpower shortage areas) should be amended by adding at the end thereof the following: "Priority for designation or assignment will be given to specialties/disciplines for which shortages have been determined by the Congress or the Secretary. Recruitment and assignment shall be made in relation to the future needs of such specialties/disciplines as determined by the Secretary, unless the Secretary has clear and convincing evidence that this shortage can be alleviated by some other Federal, State, local or marketplace mechanisms. Assignment of such individuals from specialties/disciplines with such characteristics are to be made at a higher rate than the eventual need for such specialty/discipline until the shortage for such specialty/discipline is in closer relationship to the needs for other specialties/disciplines".

With respect to institutional support, the APA believes that whichever concept emerges from the Congress must respond to the need to have a diversity of physicians who, by specialty and in the aggregate, can deliver high quality medical care to the population consistent with identified needs and accordingly, recommend that appropriate provision be made in Section

772(c)(2) of S. 2375 to include psychiatry and other shortage specialties not presently included. Further, Section 772(c)(2) should include a provision that all students (particularly those in primary care) receive substantial instruction in the biopsychosocial aspects of patient care, including prevention. We would recommend that similar revisions be made in Section 772(d)(2)(E).

S. 2144 articulates the national interest predominantly in terms of ambulatory care and shortage area practice and service. We are concerned that it fails to provide the opportunity for institutions with particular accomplishments and abilities in other areas of national need to participate in Federal initiatives to provide manpower and service solutions. Also, it is unlikely that all schools would receive the special project grants proposed under the mechanisms of S. 2144, and thus would not be eligible to receive the institutional "surgrant." We believe that the approach embodied in S. 2375 is preferable to that of S. 2144 because it provides eligibility to all medical schools to meet stated national objectives, and the opportunity to address national concerns such as increasing the supply of general and child psychiatrists, for which there are documented shortages.

Section 787, "Educational Assistance to Individuals From Underrepresented Minority Groups and Disadvantaged Backgrounds," as proposed in S. 2375 (and similarly in S. 2144 in Section 755), should be modified to articulate the need, whenever possible, to identify, recruit and select individuals from underrepresented minority groups or disadvantaged backgrounds to become physician specialists in shortage specialties such as primary care and psychiatry.

The Area Health Education Centers (AHEC) Program has been and should continue to be a useful initiative. We are pleased to see this activity continued in S.2144 and S.2375 with the requirement that there be active participation of individuals associated with departments of psychiatry. This incorporation is vital to ensure adequate exposure of medical students to biopsychosocial aspects of patient care so that they will be trained to diagnose, treat, and refer, when indicated, patients with mental disorders. We note, however, the requirement that each AHEC "assess the health manpower needs of the area served by the center (in coordination with the activities of the local health systems agency or agencies relating to such health manpower needs of the area) and assist in the planning and development of training to meet such needs". However, this provision does not contain authority which would support the provision for or conduct of medical residency training programs at such AHEC in specialties other than family medicine, general internal medicine or general pediatrics, if health manpower needs were determined to exist in specialties other than those just noted.

Because of the ambulatory nature of psychiatric residency training, the documented shortage of psychiatrists, and the existance of psychiatric shortage areas and designation criteria, it is very likely that an AHEC would determine that, in accordance with Section 740(d)(2)(B), the area served by the AHEC would be in need of psychiatrists. There, currently, however is no comparable mechanism for the training of medical specialists other than those enumerated in Section 740(d)(2)(C) to "assist in the planning and development of training programs to meet the needs which could be determined to exist. Therefore, in order to provide the flexibility for an AHEC to address particular and specific health manpower training needs envisioned in the section, we recommend that Section 740(d)(2)(B) of S.2144 and Section 781(d)(2)(B) of current law be amended by inserting ",and, in accordance with such assessment, provide for or conduct a medical residency training program in which no fewer than six individuals are enrolled in first-year positions in such program" after "needs".

With reference to the various Special Projects proposals in S. 2144 and S. 2375, the APA encourages the modification of all appropriate authorities to ensure that emphasis be given to projects which could support and enhance the education and training of psychiatrists and other shortage specialists so that ultimately the services of these physicians could be delivered consistent with the health care needs of the population. Of particular interest in S. 2375 would be revising Section 791, "Projects to Meet Needs of Medically Underserved Populations", to include after "primary care" (on page 96, line 2), "or psychiatric".

Section 793, "Preventive Medicine or Dentistry", should be amended by inserting "and psychiatry" after "occupational medicine" on page 97, line 23; on page 98, lines 4, 16 and 20; on page 99, line 3; and by striking "field of primary care" on page 98, line 13, and inserting in lieu thereof, "fields of primary care and psychiatry". Prevention of mental illness was a key concern of the President's Commission on Mental Health, and should be emphasized in this new program.

With regard to Special Projects under Part C of S. 2144, the APA believes that all appropriate components of this section should include courses of instruction in the "biopsychosocial aspects of medical patient care". We further would recommend that if the "surgrant" concept in S. 2144 is adopted that psychiatry be included in Section 731(b)(5) because of its shortage status and the fact that the percentage of American medical graduates who have entered psychiatry has dropped from 12.6% in 1970, to approximately 3.5% in 1979.

The APA supports Section 752, "Curriculum Development", of S. 2144 but would recommend psychiatry be added to the list of areas which could receive support. Psychiatry curricula should be enhanced at medical and osteopathic schools in order to increase the likelihood that more students will choose a career in the shortage specialties of general and child psychiatry, as well as be more skilled, knowledgeable, in the biopsychosocial aspects of patient care.

Additional Recommendations for S. 2378

Title I - Health Care Management

The APA shares the belief that there need to be improvements in health care management. For necessary services to be delivered in a cost-efficient manner, an adequate number of individuals must be available who will understand the management needs of entities such as private psychiatric hospitals, CMHC's, or a facility in a health manpower shortage area.

Title II - Special Projects and Experiments

As hereinbefore articulated, we recommend that S. 2378's findings be amended on page 14, line 7, to include specific reference to the shortage of psychiatrists by inserting "psychiatric services" after "primary health care".

We commend the recognition accorded psychiatry in Section 202, which allows the Secretary to support innovative psychiatric residency programs.

With regard to Section 202(b)(1) relating to preventive medicine residencies and Section 202(c), the APA, because of its previous comments to Section 201(a), believes that specific statutory recognition of the needs to increase residency training in psychiatry be included.

We heartily endorse the specific eligibility in Section 202(d), for psychiatric residency programs designed to address ambulatory care training.

With regard to Section 202(b) relating to preventive medicine residencies, the APA believes that further emphasis needs to be paid to the preventive aspects of mental illness and that the incorporation of psychiatric aspects of prevention are an integral part of any such residency program. With reference to Section 202(c), the APA believes that because of the acknowledgement that has been made of the shortage that currently exists for psychiatrists, that specific mention be made statutorily of psychiatry.

In addition, we have approved the provisions in Section 202(e) which would support approved residency training programs that prepare residents for teaching medical students and other hospital staff in techniques of teaching, supervision, consultation, career development, and evaluation methods suited to the clinical setting. Further, the APA would encourage the inclusion of the phrase "biopsychosocial aspects of patient care and" before the phrase "social and behavioral sciences" on page 18 at line 17. Because of the frequently inextricable nature of physical and mental illness, and the fact that the current wording of this provision does not account for the additional and necessary biological component, we recommend that this amendment be adopted.

Studies have demonstrated that the quality of medical student teaching is one of the factors related to the percentage of students entering psychiatry, and that higher quality programs have a sufficient well-rounded faculty, varied teaching methods, and a high degree of commitment to students. It follows that to recruit more potential psychiatrists we must conduct good teaching at medical schools, with a high degree of commitment on the part of the faculty. Teaching at the residency level must also involve both instruction in administration and exposure to exciting administrative experiences, teaching in "how to teach", and learning how to work with primary care physicians.

The programs proposed for physician residents to be exposed to the social and behavioral sciences should include a requirement, however, that physician residents (particularly those in primary care) receive training in the biopsychosocial aspects of direct patient care in inpatient and outpatient health care settings.

Our concern and comment is founded in the need for physicians to be able to diagnose, treat where appropriate, and refer when indicated, patients with mental disorders which may present themselves or be perceived as having a physical etiology. By not specifically understanding and recognizing the varied aspects of mental dysfunction, and the psychological and somatic interrelationships in physical symptomatology, the physician resident may not gain the total knowledge needed to assist patients who come to a general physician for treatment. This is particularly true for primary care physicians, who, according to a 1976 study, treated 43.6% of mental disorders presented to all physicians.

Subpart B--Experiments

We recommend that in order to ensure that emphasis be placed in the most needed areas of reimbursement, that page 20, line 8, "(such as primary care and psychiatry)" be inserted after "undersupplied physician specialties", and that on page 21, at line 20, "and in psychiatric service delivery" be inserted before the period.

Title III - Alien Graduates of Foreign Medical Schools

The APA supports the proposal to amend Section 212(j)(1)(D) of the Immigration and Nationality Act which would allow FMG's who have passed the Visa Qualifying Exam (VQE) to come to this country and remain for the period of time required to establish eligibility to take specialty examinations. Current law, which allows FMG's who have passed the VQE to come to the U.S. for two years to pursue medical education and to remain for an additional year if the visitor's home government approves, does not provide such FMG resident physicians adequate time to meet eligibility requirements of most medical specialty certifying boards, requirements which may be assumed to reflect the necessary period of training for a designated specialty. We believe that the proposal in S. 2378 to amend Section 212(j)(1)(D) is a reasonable approach which would allow an alien physician to complete residency training. An alien graduate medical education student currently is required to meet the VQE and language requirements, thus assuring his or her competence.

The APA shares the concern that by extending the "substantial disruption waiver" provision, institutions will not be encouraged or forced to address what is predominantly an educational quality issue. We do not wish to discount the service needs of populations served by residency programs which have become dependent on FMG's. Considerable thought should be given to alternative approaches which would improve these programs so that they would be attractive to U.S. medical graduates and so the populations served can receive quality medical care from U.S. medical school graduates or qualified foreign medical graduates.

The APA supports the statutory designation of hospitals with more than 25% FMG residents as health manpower shortage areas as defined in Section 332 of the PHS Act. While most beneficial to psychiatric training, we oppose the proposal allowing for the creditability of service obligation for the period of graduate medical education received at hospitals with a significant dependence on FMG's. The NHSC program's intent has always been to provide fully qualified physicians to deliver medical care to underserved areas and populations. In fact, the Corps continues to emphasize the placement of physicians who are board-eligible or board certified. By adopting this creditability provision, while self-serving for psychiatry as a medical specialty, we are concerned that the purpose of the Corps would be compromised and the medical needs of the patients in the service areas would be "shortchanged".

We appreciate the opportunity of submitting this statement for your consideration and welcome the opportunity of working with the Committee to ensure that Federal health manpower legislation responds to our citizens who are in need of treatment for mental illness.

STATEMENT
OF THE
AMERICAN COLLEGE OF SURGEONS
AND THE
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
ON
HEALTH MANPOWER

Submitted to the

Subcommittee on Health and Scientific Research
Committee on Labor and Human Resources
United States Senate

PHYSICIAN MANPOWER

A STATEMENT BY
THE AMERICAN COLLEGE OF SURGEONS
AND
THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The American College of Surgeons and the American Association of Neurological Surgeons have repeatedly enunciated the principle that the best care is provided when fully educated and experienced practitioners are given practice privileges for which such preparation and qualifications prepare them.

Consistent with this principle is the firm conviction of both ACS and AANS that an adequate number of surgeons must be educated if the nation's need for surgical care of high quality is to be met. The importance of surgical residency training programs cannot be overstated. Besides assuring the education of qualified surgeons, surgical residency programs provide resources for the advancement of medical knowledge and standards of surgery; society benefits from wide application of these advances in surgical care. An adequate supply of surgeons for teaching and research is also necessary to assure the quality of these training programs.

Determining an adequate number and an appropriate distribution of physicians is today a matter of major concern to both the public and the private sector. A shortage of physicians or a maldistribution by specialty could seriously deprive patients of ready access to the health-care system and lower the quality of care.

Measuring Physician Adequacy

Physician-to-population ratios are commonly used to measure whether the supply of physicians is adequate to meet patients' demand for care. Such ratios are an overly simplistic measure because they fail to take account of the many variables affecting the availability of physicians' services. Planning for physician manpower requires the evaluation of many more factors than physician-to-population ratios. Some of the major factors are the productivity of physicians and their patterns of referral; practice organization; the supply, function, and employment of nurses and allied health personnel; patient accessibility to services and facilities, and the characteristics of a region's population. Moreover, the adequacy of the supply of physicians cannot be determined without considering the quality of services provided. Many recommendations for the appropriate number of practitioners have ignored the level of training or the qualifications of the practitioners providing care.

More sophisticated approaches to manpower planning have sought to evaluate patient need for physician services. The terms "need" and "demand" are often used interchangeably, but a clear distinction is necessary in discussions of medical care.

"Need" may be defined as the type and range of medical services that a population ought to consume to maintain an acceptable level of health. Yet when need has not been quantified with any degree of accuracy, reliance on such a basis for manpower planning is improper because it ignores the propensity of patients to seek services or their ability to purchase them. Basing estimates of physician manpower on need seems a futile exercise, especially when one considers that need for care is potentially insatiable.

"Demand" may be defined as the quantity or volume of service actually consumed. Many variables influence patients' demand for care. Individual characteristics, such as lifestyle or occupation, influence health levels. Socioeconomic or cultural background may influence a patient's propensity to seek care. Aggregate demand for care is influenced by changing demographic and financial factors, such as an aging population and increasing insurance coverage. New technologies, both diagnostic and surgical, may increase demand for care, since they make possible the treatment of many conditions previously undetected and inoperable. As the American public becomes more knowledgeable about matters of health, its expectations for medical care are raised, and demand for services, especially for care by specialists, may increase.

Supply and Distribution of Specialists

Recently, the emphasis on the total supply of physicians has decreased and the emphasis on the supply of various specialists has increased. A widely accepted notion has evolved that there is a shortage of primary-care physicians and a surplus of specialists. This perceived shortage of primary-care physicians suffers from a lack of documentation and imprecise or inappropriate definitions.

The literature provides no firm basis for the contention that a shortage of primary-care physicians exists; the belief that increasing the number of primary-care physician will allow the public to have "access on demand" to a physician remains undocumented. Definitions of "primary care" are imprecise. Some suggest that the term relates to the level of complexity in treatment or to the stage of the presumed illness when the patient first sees a physician. Others suggest primary care as a label for the services provided by the specialties of general internal medicine, family practice, and general pediatrics, or according to some, obstetrics-gynecology.

The discussion about supply and distribution of specialists is hampered by the lack of data and the unreliability of methods to determine the optimal range and volume of services provided by a physician in any specialty. Relying solely on specialty designation is fallacious. The kinds of services provided by a physician may depend as much on the medical needs of a community or the individual patient as on the physician's specialty label. When specialists are obviously providing what is imprecisely defined as primary care, simple ratios of specialists to generalists cannot be used in manpower planning, particularly when the generalists also provide a certain amount of secondary or tertiary care.

The ultimate "proof" of the shortage of primary-care physicians is assumed to lie in the failure of the nation to meet arbitrarily determined ratios of primary-care physicians to population. Yet criteria for determining shortages may be changed at any time to justify actions aimed at increasing the supply of primary-care physicians. Recent regulations for designation of health-manpower shortages areas arbitrarily modified the suggested ratio of primary-care physicians to population from 1 per 4,000 to 1 per 3,500. Health-planning goals proposed by HEW would modify this ratio to 1 primary-care physician equivalent per 2,000 population. Criteria for determining shortage areas were also modified to exclude the contribution by specialists to primary care, such as by general surgeons practicing in rural areas.

Improper geographic distribution has been cited as a reason to increase the number of certain types of physicians in the United States. However, recent studies indicate that surgical specialists are quite well distributed throughout the country, even in counties of under 10,000 population.

Residency Programs

Residency training programs have become the focus of attempts by government to adjust the distribution of physicians by specialty and location. The physician manpower training act passed in 1976 specified that to be eligible for capitation grants, medical schools must meet certain percentage requirements for first-year residency positions in primary care specialties. This law and previous legislation, together with voluntary changes in physician specialty selection, have increased the proportion of first-year residents in primary-care specialties to more than fifty percent of the filled first-year residency positions. A similar trend is evident in board-certification of specialists: the number of certificates issued in the primary-care specialties has in recent years exceeded fifty percent of all certificates.

In addition to the shift in specialty choice by residents, other trends in physician training are influencing the supply of specialists. Manpower legislation has also reduced the supply of foreign medical graduates (FMGs) entering the country; those who do enter for residency training are prevented from completing training in most specialties because of restrictions on the duration of their stay. Women now comprise over 20 percent of medical school graduates. Because women have had a greater tendency to enter primary-care specialties in the past their increasing numbers may influence the specialty distribution of physicians.

Because the supply of domestic medical graduates is leveling off, and the number of FMG residents has been reduced, any increase in primary-care training positions must subtract from the number of those positions available for all other specialties. This raises the serious risk of not producing enough specialists to meet patients' demand for specialty care of high quality. The probability of a specialty imbalance is heightened by the possibility that changes mandated by government will be added to changes already occurring voluntarily in the private sector.

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Conclusions

Recognizing the complexity of the issues involved in manpower planning, the American College of Surgeons and the American Association of Neurological Surgeons wish to emphasize the following:

1) The interests of the public are best served by assuring an adequate number of both generalists and specialists to meet patients' demand for high-quality medical care. Efforts to determine an adequate number and appropriate distribution of physicians must consider all variables in patients' demand for medical services and in the way that physicians practice. Simplistic physician-to-population ratios are not an acceptable measure of adequacy of physician supply.

2) Because of the long training period for physicians, the effects of changes in residency training on the supply of practicing physicians do not become evident for several years. The long-term effects of previous legislation and of voluntary changes in preferences for medical specialties should be evaluated before the current system is modified.

3) The concept of "primary care" should be either clearly defined or dropped as a manpower designation. The arbitrary classification of certain specialties as "primary care" does not consider the nature of the care provided by both generalists and specialists.

4) The phenomenon of "leakage" from such primary care specialties as general internal medicine into more specialized fields has been used to justify an increase in the proportion of primary care residency positions. It would be more rational to stop the leakage rather than to produce more generalists at the expense of reducing the supply of specialists.

5) Some foreign-trained physicians should be allowed to remain in the United States as long as necessary to complete residency training in the specialty of their choice.

6) Efforts to improve the availability of medical care to underserved areas should include improved arrangements for referring and transporting patients to currently available resources for medical care.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

asa

March 26, 1980

The Honorable Jacob K. Javits
321 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Javits:

We are grateful to have the opportunity to present the views of The American Society of Anesthesiologists on S.2378 introduced by you. We recognize that your bill, for the most part, refers to individuals in primary care. However, there are some areas that may well apply to anesthesiology and, therefore, we wish to make the following comments.

Page 16, Lines 13 to 20. "The Secretary may make grants to and enter into contracts with schools of medicine and osteopathy, teaching hospitals, and other appropriate entities to assist in meeting the costs of projects to plan, develop, operate or maintain a physician residency training program in physical medicine and rehabilitation and physician residency training programs in other non-primary care specialties designated to be in undersupply by the Secretary."

COMMENT

It is well recognized that anesthesiology is a specialty in undersupply. Therefore, we support such a provision in the law.

Page 18, Lines 1 to 15, deals with making grants available to schools of medicine and osteopathy to meet the educational costs of innovative programs for residents in approved residency programs that prepare residents for teaching medical students and other hospital staff.

COMMENT

We strongly support such grants which appear to be designed for training in education. There is a definite need for such grants in the field of anesthesiology.

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Page 25, Lines 7 to 11. "Public and private nonprofit hospitals with accredited residency training programs in which more than 25 percent of the residency positions in any such program are filled by alien graduates of foreign medical schools shall be deemed to be health manpower shortage areas."

COMMENT

We believe this to be a provision of the bill which could, at the very least, be misleading. The fact that 25 percent of the residency physicians in any such residency program are alien graduates of foreign medical schools may be a reflection of the quality of the training program as much as any other determinant. For example, there are residency programs in large cities that are comprised almost exclusively of American medical graduates and other programs in the same city consisting primarily of foreign medical graduates.

A few weeks ago, we presented our views to Senator Schweiker on his S.2144, which describes the position of this Society on health manpower issues in considerable detail. We attach a copy of this testimony for your information.

Again, let me express our appreciation for this opportunity to present our point of view on this legislation. If we can be of additional assistance, please do not hesitate to call on us.

Sincerely,

John S. Hattox, Jr.

John S. Hattox, Jr., M.D.
President

Enclosure

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

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The Honorable Richard S. Schweiker
253 Russell Senate Office Building
The United States Senate
Washington, D.C. 20510

Dear Senator Schweiker:

Thank you for having solicited the comments of The American Society of Anesthesiologists (ASA) as you and the Senate Subcommittee on Health and Scientific Research begin to consider successor legislation to the Health Professions Educational Assistance Act of 1976 (PL 94-484). We are grateful to have this opportunity to present our views on such important legislation.

ASA is a national professional organization of some 15,000 physicians specializing in the practice of anesthesiology. I am responding to your inquiry in my capacity as the current President of ASA. I would be remiss, however, if I did not acknowledge the fact that this response was prepared principally through the work of the Chairman of ASA's Committee on Manpower, Fredrick K. Orkin, M.D., of Philadelphia, Pennsylvania.

Among the most pressing problems confronting this specialty is the issue of the most appropriate method by which to finance graduate medical training. This is a complex problem which affects all specialties and about which a variety of public and private groups are deliberating. In short, the current mode of financing residency training -- hospital-generated revenues -- is under increasingly severe pressure because of three trends: (a) State and third-party payors increasingly question whether training should be financed by patient-care revenues; (b) hospital cost containment initiatives are forcing training programs to compete with service programs for diminishing funds; and (c) as funding for research training and fellowships diminishes, there is increased pressure to finance at least some research trainees as residents, aggravating the other two trends.[1]

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[1] Knapp RM, Butler PW: Financing graduate medical education. N Engl J Med 301:749, 1979

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The argument that there should be a federal role in financing graduate medical education rests upon several undeniable facts. First, the young physician undergoing the training cannot pay because, as you noted when introducing S.1642,[2] the cost of the medical education that precedes postgraduate training is escalating so rapidly that it is almost beyond the ability of all but the most affluent families.[3] Second, as noted already, hospitals cannot absorb costs associated with training, and similarly, the teaching physicians should not be expected to pay the residents, as former Pennsylvania insurance commissioner Herbert Denenberg once suggested, because these dedicated teachers are already generally earning substantially less than their colleagues in nonteaching hospitals. Finally, the states that support resident training should not be expected to increase their support because the newly trained physician is mobile and, thus, a national resource.

Given the changes wrought in other aspects of federal health manpower policy recently, we believe that graduate medical education should continue to be financed largely through hospital patient-care revenues, because of its historical stability of this source, as well as the absence of a satisfactory alternative. We note that the unified-fee method, recommended by some, which would lump hospitals' and physicians' fees into a single charge, would merely shift the financing decisions to the hospitals without providing a remedy. Among numerous defects in this method is the inherent incentive for increases in the fee, which would be detrimental to cost containment, as well as the educational purposes underlying the training. State and federal programs to pay educational costs directly are unwise, given the instability engendered by an annual appropriation mechanism and by the recent experience with capitation programs.

Another pressing manpower problem facing our specialty is the sharp decrease expected in the number of physicians embarking upon training in anesthesiology, much of which will be due to the foreign medical graduate (FMG) exclusion mandated by PL 94-484. As you may know, our specialty has had a disproportionately large FMG representation among those in training: Above 50 percent during 1966-75, reaching a high of 57.8 percent in 1972, and gradually decreasing since 1972 to reach 38.2 percent in 1979,[4] before FMG exclusion had a full effect. In time, the FMG title may enhance the appeal of the specialty among prospective US medical graduates who may have been wary of entering programs populated predominantly by non-Americans, and, thus, result in a greater percentage of US graduates entering the specialty, partially compensating for the decreased number of FMGs. However, in the near future, the absolute number of physicians entering our specialty is likely to decrease sharply.

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[2] Schweiker RM: Congressional Record, August 2, 1979

[3] Ability to pay looms as admission criteria for '80s. AM News, p.1, December 28, 1979

[4] American Society of Anesthesiologists' data

Although it is too early to know the numerical effect of FMG exclusion, by the mid-1970s, before FMG exclusion, a trend was already apparent in the number of filled, first-year residency positions in anesthesiology: 799 in 1972, 715 in 1974, and 570 in 1976.[5] Using such data, the Graduate Medical Education National Advisory Committee (GMENAC) has projected minimal growth for this specialty: 15,600 (3.6% of US MDs) in 1980, 16,210 (3.2%) in 1985, and 16,830 (2.9%) in 1990;[6] again, these projections do not consider the marked FMG exclusion resulting from PL 94-484.

Moreover, anesthesiology manpower projections have not taken into account the relative youth of the specialty, which promises increased attrition in the 1980s. In 1972, 82 percent of anesthesiologists were under 55 years of age, compared to 73 percent of all medical specialists.[7] As a corollary, the number of retired members of ASA (to which about 95 percent of all anesthesiologists in this country belong) was only 0.6 percent of the active membership in 1960, grew to 2 percent in 1970, and reached 3 percent in 1976.[8] Hence, during the 1980s, the anesthesiology manpower pool will experience losses at a greater rate as the specialty ages. With deaths and retirements removing a little over 500 anesthesiologists each year, and with fewer entrants in the next few years, it is expected that the anesthesiology manpower pool will contract, unless the percentage of US graduates increases.

However, given the growing pressures toward primary care training -- in particular the diversion of 50 percent of first-year residency positions into primary care specialties -- this specialty is unlikely to recruit even its customary three percent of US graduates. The requirement that at least 65 percent of these positions be in primary care, contained in your bill, The Health Professions Educational Assistance and Nurse Training Act of 1980 (S.2144), will undoubtedly aggravate a critical situation. Recruitment is also threatened by those national health insurance bills, such as S.1812, which propose to change reimbursement for anesthesiologists from fee-for-service to a cost basis through the hospital.

The argument for a federal role in resolving the problem of a likely decreasing supply of anesthesiologists rests upon the mobility of physicians and the need for comprehensive, stable manpower policy rather than a state-by-state approach. Historically, federal health manpower policy has been based upon incomplete, unreliable, or inappropriate data, and mostly upon opinion.[9] For example, the number of medical students graduating each year has doubled during the past ten years in response to federal manpower policy designed to treat a "shortage" of physicians. Now it is recognized that the absolute number of physicians is not the problem, but rather the uneven geographic and specialty distributions; so manpower policy is being changed drastically. Yet, data are very limited on where physicians should be redistributed, how many primary care physicians are really needed, and which specialties are overproducing physicians.[10] Underlying these questions is the problem of estimating the need for physicians, which is especially difficult in this specialty. This problem was highlighted recently by a Bureau of Health Manpower study[11] which predicted an "oversupply" of anesthesiologists in 1980; however, when deficiencies in their methodology and data were identified,[12] the authors concluded that no oversupply would be present in 1980 and that undersupply would exist after 1980.[13]

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[5] American Medical Association: Director of Approved Residencies. Chicago, American Medical Association, various years

[6] Graduate Medical Education National Advisory Committee: Interim Report of the Graduate Medical Education National Advisory Committee to the Secretary. DHEW Pub. No. (HRA) 79-633. Table 14, p. 153, April 1979

[7] Ament R: Delivery of anesthesia care: present and future. NY State J Med 72:2179, 1972

[8] Orkin FK: A critique of the Bureau of Health Manpower estimates of the need for anesthesia manpower. Med Care 16:878, 1978

Your inquiry about imbalance in the distribution of anesthesiologists, prompts a few general comments about "geographical maldistribution". It is well known that the geographical distributions of medical specialists are uneven,[14] and this is true as well for anesthesiologists.[15] The critical question is how much of the unevenness in the distributions serves a social purpose and how much constitutes "maldistribution". For example, does the society want to perform elective surgery, especially high-risk procedures, in small hospitals having fewer than 100 beds (which comprise about half of the hospitals in the US?[16] A very recent study[17] argues for regionalization of surgery by demonstrating that mortality following high-risk surgery decreases with increasing numbers of procedures; presumably morbidity and cost are also sensitive to the frequency with which a surgical procedure is performed. Voluntary regionalization has begun in cardiac surgery and obstetrics; undoubtedly the trend will continue, spurred on by public concern for both cost containment and quality of care. Anesthesiologists have traditionally located in tertiary care centers where highly complex surgical procedures (i.e., open heart surgery, renal transplantation, vascular procedures) are undertaken. Shortage of anesthesiologists in these locations would seriously impair the ability to perform these operations on poor risk patients. This would not be in the best interest of the American public.

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[9] Bloom BS, Peterson OL: Physician manpower expansionism: a policy review. Ann Intern Med 90:249, 1979

[10] Hadley J: Medical Education Financing: Issues and Options. DHEW Pub No.(PHS) 79-3261. October 1979

[11] Roddy PC, Hambleton R: Supply, need, and distribution of anesthesiologists and nurse anesthetists in the U.S., 1972 and 1980. Med Care 15:750, 1977

[12] Supra at 8.

[13] Roddy PC: Response to Dr. Orkin. Med Care 16:886, 1978

[14] Institute of Medicine: Medicare-Medicaid Reimbursement Policies. IOM Pub. No. 76-01. Washington, National Academy of Sciences, March 1976

[15] Orkin FK: Analysis of the geographical distribution of anesthesia manpower in the United States: Anesthesiology 45:592, 1976

[16] Hospital Statistics, 1978, Chicago, American Hospital Association, 1978

[17] Luft HS, Bunker JP, Enthoven AC: Should operations be regionalized? The empirical relation between surgical volume and mortality. N Engl J Med 301:1364, 1979

We have no data regarding the relationship between student financial aid and the choice of practice mode and location for physicians in anesthesiology, about which you also inquired. Although financial aid programs and incentives have had only a small effect on the medical student's decision-making in the past, the rapidly escalating cost of medical education[18] should enhance the effectiveness of such initiatives.

In view of the shortage of anesthesiologists expected in the near future,[19] we recommend strongly that federal policy identify anesthesiology among those specialties that need special support and incentives to attract trainees. We also suggest that, given the history of health manpower policy, other manpower decisions should be delayed until better information becomes available, or made only with the greatest caution.

Thank you, once again, for inviting us to present our views on the manpower situation in anesthesiology, in particular the expected decrease in the number of anesthesiologists, and health manpower legislation. If we can be of further assistance, please do not hesitate to contact us.

Very truly yours,

/s/

John S. Hattox, Jr., President

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[18] Supra at 3

[19] Supra at 8,13

UNITED STATES SENATE

LABOR AND HUMAN RESOURCES COMMITTEE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

Statement
Submitted by the

Association of Physician Assistants Programs

on

Physician Assistant Education
and
Proposed Health Manpower Legislation

For More Information Contact:

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STATEMENT

TO THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

LABOR AND HUMAN RESOURCES COMMITTEE

OF THE

UNITED STATES SENATE

BY THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

ON

PHYSICIAN ASSISTANT EDUCATION
AND
PROPOSED HEALTH MANPOWER LEGISLATION

March 25, 1980

The purpose of this document is to present our rationale for proposed future support for physician assistant training programs. The report is divided into two (2) sections. The first section describes the evolving nature of today's health problems and the impact of physician assistants in the delivery of care in this evolving system. The impact is described in terms of economics of care, access to care, and quality of care. The second section offers specific recommendations on future funding of physician assistant training.

By way of information, the Association of Physician Assistant Programs (APAP) represents over fifty training programs for physician assistants (PAs). Since its founding in 1972, the Association has been providing information about the PA profession, developing and evaluating educational curricula, assisting in the development of a role delineation for the PA, developing continuing education programs, and conducting research on the

PA profession. These research results have been made readily available to the public, Congress, foundations, and institutions of higher learning.

The Association's member programs graduate approximately 1,500 PAs annually from programs based in twenty-eight states. To date, over 10,000 graduates have been produced. APAP programs carry various titles such as physcian assistant, MEDEX, physician associate, child health associate, and family nurse practitioner, yet, each is involved in educational activities which train assistants to the primary care physician.

SECTION I: Evolving Nature and Impact of Physician Assistants

Introduction

A host of statistics document that Americans are living longer and are healthier today than ever before. The dramatic decline in mortality from infectious disease since 1900, particularly in infancy and childhood, has been accompanied by a significant increase in life expectancy at birth.[1]

While medicine and public health measures contributed significantly to these improvements in the health status of U.S. citizens, the degree of impact during the past 20 years has been much less than in the preceding 20 years. The age-adjusted mortality rate has slowed to less than one percent per year.[2] Since the 1950's, life expectancy for adults has increased by only a small margin and the major health problems of today are the result of multiple factors and have only recently been deemed amenable to prevention.

Currently, the major health problems facing society-at-large are cardiovascular disease, accidents and violence, cancer, mental illness, respiratory disease and arthritis. Accidents, suicide and homicide are the prime causes of death among persons in the age groups of one to thirty-eight years. Chronic illnesses, including those associated with aging, are the primary causes of disability and death in middle age and later life. The longevity resulting from medical advances creates a situation where chronic diseases now affect many more persons for longer periods of time than was previously the case. This situation often imposes extended burdens on the patient and his or her family, and on society as well.

With this change in the nature of our health problems and the impasse that seems to have been reached in relying on crisis-oriented care as the means of solving these problems as well as the documented maldistribution and over specialization of our health care providers, it is imparative that the Congress of the United States enact legislation that places greater emphasis on health promotion and protection as well as to adequately address the maldistribution and over-specialization of our health care providers. The potential for implementing a system of health care delivery focusing on these issues exists today, and can be realized by using (PAs).

The Physician Assistant

The PA profession has experienced a rapid rate of growth since the first program began in 1965. In 1967, the National Advisory Commission on Health Manpower reported, "The development of health personnel at the intermediate professional level has been repeatedly explored ... We recommend that the federal government give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals."[3] By the early 1970's the National Center for Health Services Research and Development funded pilot programs for MEDEX and physician assistants. In 1970, the American Medical Association defined the PA as "... A skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[4] Further development of the PA profession was encouraged by Congress with passage of the Comprehensive

Health Manpower Training Act of 1971, which provided funds for the implementation of new PA programs.

Strict standards for training and certification have been developed. In 1971, educational essentials for PA programs were developed by the American Medical Association in collaboration with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine.[4] These organizations formed the initial Joint Review Committee on Educational Programs for Physician's Assistants later joined by the American Academy of Physician Assistants and APAP, which is responsible for reviewing the results of on-site evaluations to PA programs. The Committee makes recommendations for program approval to the Committee on Allied Health Education and Accreditation (CAHEA, initially the Council on Medical Education, AMA).

In 1973, the National Board of Medical Examiners first administered a national certifying examination, which now is administered annually under contract from the National Commission on Certification of Physician Assistants (NCCPA). This National Commission maintains a record of all certified PAs and requires continuing medical education for biannual reregistration with recertification being required every six years.

The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) authorized the continuation of federal support for PA training programs. PA program funding has had so many beneficial results that the effort should be continued. The benefits are described in the sections which follow.

Role of the PA in Practice

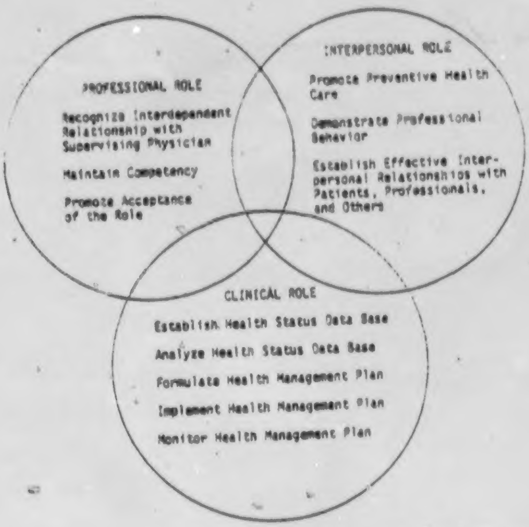
Three comprehensive roles or areas of competence are included in the role delineation for the PA. They can be described briefly as follows:

Professional Role -- the competence necessary for assuming, maintaining and developing a role identity as a physician assistant

Interpersonal Role -- the competence necessary to effectively communicate with other people

Clinical Role -- the competence necessary to apply medical knowledge and skills to patient problems

Eleven major responsibilities are defined for the competent PA. They fall roughly into the three areas of competence, as shown below.


PROFESSIONAL ROLE
Recognize Interdependent Relationship with Supervising Physician
Maintain Competency
Promote Acceptance of the Role
INTERPERSONAL ROLE
Promote Preventive Health Care
Demonstrate Professional Behavior
Establish Effective Interpersonal Relationships with Patients, Professionals, and Others
CLINICAL ROLE
Establish Health Status Data Base
Analyze Health Status Data Base
Formulate Health Management Plan
Implement Health Management Plan
Monitor Health Management Plan

As can be seen, the three PA roles are overlapping. For example, a PA does not perform clinical tasks without also engaging in professional and interpersonal behaviors. The Professional Roles and Interpersonal Role competence areas are all-encompassing; each major responsibility in these two areas is interactive with all other major responsibilities. Furthermore, the notion of promoting preventive health care has been identified as a major responsibility of the PA thus lending support to the need for continued training of the health professional.

The major responsibilities of the clinical roles contain considerable detail concerning the patient data to be collected, patient problems to be acted upon, tests to be used, and therapeutic activities to be undertaken. The patient problem activities are: establish preliminary diagnosis, validate preliminary diagnosis, establish working diagnosis, formulate plan, and provide treatment. The activities concerning tests are: order, perform, interpret raw data, and interpret written report.

The relationship between the PA and the supervising physician is explicitly stated. PAs practice under the responsible supervision of a licensed physician and PAs carry out only those activities explicitly delegated by the supervising physician.

PA Impact - Access and Deployment

Available data reveal a wide distribution of PAs throughout all fifty states, with the majority practicing in primary care settings.[6,7] Forty-five states have enacted legislation recognizing and regulating the practice of physician assistants.[5] Scheffler surveyed post-entry level PAs and found graduates were practicing in non-metropolitan areas more frequently than physicians.[8] Geographically, over one-third of

PAs are practicing in rural areas where 25% of the U.S. population resides. This compares to only 13% of physicians practicing in rural settings.[9] Other data show 53% of PAs in communities of 50,000 population or less where 37% of the population resides, but only 28% of physicians choose to practice.[10] Finally, several studies have revealed a positive relationship between location of the training program and the location of their graduates.[11,12,13]

Relative to the provision of care, two large surveys show that between 73% and 83% of PAs are providing primary care services.[7,10] A majority of these, 44% of all PAs, are working with family practice physicians. PAs are also providing care in public hospitals (10%) and community public health clinics (9%). Another 16% report working in remote or satellite clinics where direct physician services are not always available.[7] Approximately 100 PAs currently serve in the National Health Service Corps, with many more on the waiting list.

PAs have improved patient access to care by increasing the availability of health care services given their geographical distribution and diffusion into the primary care marketplace. Increased productivity measures also improve patient access for more patients are able to be seen. Hershey and Knopp have, in fact, reported that linear program results increase productivity by 90% (185 patients per week).[14] Because of these factors, demand for PA graduates remains high and unemployment statistics for the profession remain extremely low (3%)[7].

Economic Productivity

Research on PA productivity is quite favorable. PAs do increase the volume of office visits and can improve patient access to care by expanding the physician's practice. Controlled studies of MEDEX graduates in Washington State and New England reinforce this conclusion with practice productivity increases measured from 37% to 50%.[15] A study of rural California practices revealed PAs were quite productive, averaging 19 patients per day.[16] A study performed for the Social Security Administration concluded that practices with new health practitioners are 50-70% more productive by number of visits than controls.[17] The study also found that utilization of a PA allows more time per patient visit and increases gross practice revenues by 42% to 51%. Hershey and Knopp reported (1979) that when a linear programming model is used, one would conclude that 393 patients can be seen per week in a practice with a PA and 208 patients in a practice with no PA. "Thus the addition of the physician assistant would increase productivity by about 90%, according to the linear programming results."[14] Finally, after performing extensive research and analyzing the literature, Record has stated "... the data strongly suggests that new health practitioners are safely substitutable for primary care physicians in a large percentage of outpatient visits...and ... that new health practitioners are capable of performing at high levels of productivity."[18]

It has also been concluded through empirical research that PAs are cost-effective if properly employed in private practice.[19] Jane Record estimates a cost-saving of $20,000 per year per PA employed in a health maintenance organization.[20] This is due, in part, to the salary differential between a PA and a physician. Studies of PAs in rural primary care practice, however, reveal problems caused by a lack of Medicare reimbursement.[21] The relatively new Rural Health Clinic Services Act (P.L. 95-210) will not rectify this situation entirely, due to restrictive regulations developed by the Health Care Financing Administration. Recently, the Institute of Medicine Primary Care Study recommended equal reimbursement for PA and physician services under Federal programs to resolve this significant problem.[22] The data cited above and other research support the conclusion that PAs are cost-effective in both the private and public settings.

Further evidence of the economic productivity of PAs is revealed in a study by Blake and Guild on "Mid-Level Practitioners in Rural Health Care: A Three Year Experience in Appalachia." Their findings indicate that during the first three years of operation of three (3) rural southern Appalachia clinics, 76% of the geographically defined population of 5,500 received services. PAs and NPs provided care in half of the 40,252 medical encounters and 89% of their contacts were managed without consultation with or referral to the physician. They further reported that the PAs managed 36% of first year visits, 51% of second year visits, and 54% of third year visits. Population surveys indicated that consumer satisfaction with PA services is high and that health care from this system is perceived as being more accessible than care from alternative sources.

The impact of PA training and employment on costs can be measured in two important, yet different, ways: manpower production (training) costs and utilization (employment and care purchase) costs. Educational cost data on PAs from the National Center for Health Services Research show the training costs to be approximately $15,100 per year.[23] Many PA programs report an annual cost per student of $8,000-$12,000. Obviously, PA training costs are substantially less than physician training costs. In addition, the PA can provide about two years of service before a physician, who simultaneously began his/her education, can even begin residency.

From the above cited research it can be concluded that PAs improve access to health care in areas of greatest need and that when economic factors are considered, PAs, when utilized properly, afford considerable savings to the health care system (public dollars).

Quality of Service - Quality of Care

There are a large number of studies which validate the level of competence of PAs. Nelson[24], Pondy[25], and Henry[26] have shown patient acceptance as a function of perceived quality of care to be highly favorable. For example, Nelson found that more than 85% of patients rated PAs as highly competent and professional, and 71% reported an improvement in the quality of care. Task analysis studies find PAs performing complete history and physical examiniations, diagnosing acute and chronic disease, and providing preventive medicine and counseling services to the patient and the family under the supervision of a physician. Record reports no significant differences in morbidities or outcomes of care in primary care services delivered by PAs compared to physicians in an HMO setting.[27] A 1977 HEW report concluded that "physician assistants provide at least the same quality of care as the physicians with whom they were compared on the same task."[28] This has been further substantiated by Sox (1979) when he concluded that the quality of primary ambulatory care given by NPs and PAs was indistinguishable from that given by physicians. Most importantly, it has been stated that as a result of decreased patient waiting time and increased continuity of professional care, the inclusion of a PA in a practice was an excellent deterrent to the ever present threat of malpractice.[29]

Concerning patient acceptance of the PA, the literature is rich with studies reporting that PAs are well accepted by their patients.[30,31] A DHEW Physician Extender Work Group reviewed existing research on patient acceptance and found excellent consumer satisfaction with PA-rendered care.[32]

SECTION II: CONCLUSIONS AND RECOMMENDATIONS

Conclusions and Recommendations

A review of the available research data indicates that PAs are assuming a significant role in the delivery of health care in rural/urban areas, and by doing so are improving patient access to care. PAs are well accepted by patients, are productive, and have been identified as a resource which increases effeciency in the delivery of health care services. In addition, PAs are delivering high quality care.

The PA profession offers a significant opportunity for this country to realize its primary objective in promoting a balanced supply of health professionals to meet the health care needs of the American people. Accordingly, the Association of Physician Assistant Programs makes the following recommendations for the funding of PA training programs in health professions education legislation.

1. Federal authorization for PA training should be maintained at current levels. This is critical to guarantee the continued production of well-trained graduates at current numbers and to increase the supply of primary care health professionals. PA programs have not yet and cannot be expected to become entirely self-supporting in the period covered by the current Act (P.L. 94-484).

   Surveys conducted by the Association for PA Programs (APAP), data from the Office of Special Programs (Bureau of Health Planning), and the General Accounting Office (GAO) Report on PA Training confirm that the cost to produce a PA graudate is approximately $10,000 - $15,000 as compared to $112,400 to produce a board eligible family physician. If one accepts the average production cost figure for PAs at $7,000 per year and recognizes that 53 programs are now in need of ongoing support, with an annual production of 1,500 graduates or 30 graduates per program per year, we estimate the expenditures for eligible PA programs each year to be $11.13 million. Assuming $500 per graduate in tuition revenues per year or a total of $.75 million in tuition revenues, and assuming that state revenues will cover approximately 10% of estimated educational expenditures ($1.1 million), then $10 million in federal monies will be necessary to meet the expected expenditures of existing PA programs each year. If new programs or more graduates are to be encouraged, additional revenues must be provided.

2. PA students should be made eligible for all appropriate federal health professions scholarships, traineeships, and loan forgiveness programs.

Our experience indicates that students entering PA training are somewhat older and tend to have greater financial responsibilities than students in medical, osteopathic, dental, and nursing schools.[7,33] It has also been demonstrated that most PA students are from lower socio-economic backgrounds than the above named students.

At the present time, the requirements for traineeships for PAs do not conform to those for traineeships for NPs. Thus in any new health manpower initiative, these requirements must be made to conform. This should include but not be limited to: 1) permitting individuals who do not reside in a health manpower shortage area to receive a traineeship, but providing for special consideration for individuals who do reside in such an area, and 2) clarify the Secretary's authority to determine the service commitment required of each beneficiary.

In addition, the provisions of the current law (P.L. 94-484) governing the Health Education Assistance Loans Program should be amended in order to make PA students eligible for loans.

3. Funds not awarded for training support should be made available for educational research, continuing medical education, program evaluation and faculty development.

   The current law (P.L. 94-484) does not provide flexibility for educational research, program evaluation and faculty development. If PA programs are to evolve with changes in the health care delivery system at a rate sufficient to meet the nation's health care needs, funding must be made available to conduct educational research and to evaluate the programs effectiveness. Furthermore, money should be made available for faculty development in this rapidly evolving profession.

4. PA training funds should be authorized separate from nurse practitioner funds. This is important to prevent needless confusion over allocation of training funds.

5. Legislative priorities for awarding Physician Assistant Training Grants should be as follows.

   A. Encourage deployment of graduates to designated health manpower shortage areas and other underserved areas.

   B. Encourage cooperation of the programs with other local primary care training programs.

   C. Encourage cooperation with local Health Planning Agencies.

D. Encourage collaboration with Area Health Education Centers where available.

The Association of Physician Assistant Programs thanks the members of the Committee for inviting us to provide you with our views on this very important subject.

REFERENCES

1. Spiegelman, M. Erhardt, CL: Mortality and Longevity in the United States. In Erhardt, CL, Berlin, JE (eds): Mortality and Morbidity in the United States. Cambridge, Massachusetts; Harvard University Press, 1974.

2. MacMahon, B: Infant Mortality in the United States. In Erhardt, CL, Berlin, JE (eds): Mortality and Morbidity in the United States. Cambridge, Massachusetts; Harvard University Press, 1974.

3. Report of the National Advisory Commission on Health Manpower, Vol. 2, Washington, D.C., Government Printing Office, pp. 231-233, 1967.

4. Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician, American Medical Association, Council on Medical Education, 1971.

5. Cohen, HS, Dean WJ: To practice or not to practice: Developing state law and policy on physician's assistants, MMFQ/Health and Society, 1974.

6. Scheffler, R: Characteristics of Physician Assistants: A Focus on Specialty, The PA Journal, 5: 30-41, 1975.

7. Light, JA, Crain, MJ & Fisher, DW: Physician Assistant: A Profile of the Profession, 1976, The PA Journal, 7: 109-123, 1977.

8. Scheffler, R & Stinson, O: Characteristics of Physician Assistants: A Focus on Specialty, Medical Care, 12: 1019-1030, 1974.

9. Lawrence, D: Physician Assistants and Nurse Practitioners: Their impact on health care access, costs, and quality: Health and Medical Care Service Review, 1(2):10, March/April, 1978.

10. Perry, HB: Physician Assistants: An overview of an emerging profession, Medical Care, 15(12): 984-985, 1977.

11. Scheffler, R: The supply of and demand for new health professionals: Physician's Assistants and Medex: Executive Summary (Report #NO1-44184, unpublished report available from Bureau of Health Manpower, Division of Medicine, Health Resources Administration, USDHEW, Washington, D.C.), 1977.

12. Appel, G & Lowin, A: Physician Extenders: An evaluation of policy related research (unpublished report, prepared for the National Science Foundation, available from Interstudy), Minneapolis, 1975.

13. Morris, S & Smith, D: The distribution of Physician Extenders, Medical Care, 15: 1045-1057, 1977.

14. Hershey, JC & Knopp, DH: A Re-Appraisal of the Productivity Potential and Economic Benefits of Physician Assistants, Medical Care, 17(6): 592-606, 1979.

15. Nelson, J, Jacobs, A, Breer, P, et al: Impact of Physician Assistants on patient visits in ambulatory care practice. Annals of Internal Medicine 82: 608-612, 1975.

16. O'Hara-Devereaux, M, Dervin, J, Andrus, L, et al: Economic effectiveness of family nurse practitioner practice in primary care in California, The New Health Professionals edited by Bliss, A, Cohen, E, Aspen Systems Corp, Maryland, 1977.

17. Mendenhall, R: The Social Security Administration study of PA and NP reimbursement, presented at the Semi-Annual Meeting of the Association of Physician Assistant Programs, New Orleans, Louisiana, October 1978.

18. Record, JC: Primary care by non-physicians: What a decade of experience offers to policy-makers. The productivity issues. (DHEW BHM, HRA), Hyattsville, Maryland, 1978.

19. Golladay, F, Miller, M & Smith, K: Allied health manpower strategies: Estimates of the potential gains from efficient task delegation, Medical Care, 33: 457-469, 1973.

20. Record, JC, et al: Cost effectiveness of physician's associates: Kaiser-Permanente experience; Kaiser Foundation Health Services Research Center, Portland, Oregon (Unpublished paper presented to the Health Economics Organization, American Economics Association, Dallas, Texas) 1975.

21. Hill, R, Greenwood, J, Wert, FS: Case study of remote clinic manned by a Physician Assistant, Public Health Reports, Winter, 1979.

22. Institute of Medicine: A Manpower Policy for Primary Care, National Academy of Sciences, Washington, D.C., 1978.

23. National Center for Health Services Research, Health Resources Administration, Department of Health, Education and Welfare. Nurse Practitioners and Physicians Assistants Training and Deployment Study, September 30, 1976.

24. Nelson, EG, et al: Patient acceptance of physician's assistants. JAMA, 228: 63-67, 1974.

25. Pondy, LR: Utilization and productivity of the Duke physician associate, PA Journal, 228: 4: 32-53, 1974.

26. Henry, RA: Use of physician's assistants in Gilchrist County, Florida. Health Services Report, 87: 8 687-692, 1972.

27. Record, JC, et al: Evolution of a physician's assistant program in the Kaiser-Permanente System: Policies, practice patterns, and quality of care, Kaiser Foundation Health Services Research Center, Portland, Oregon (unpublished paper presented to the Fourth Annual Conference on New Health Practitioners, Atlanta, Georgia) April, 1975.

28. National Center for Health Services Research, Health Resources Administration, Department of Health, Education, and Welfare: Nurse Practitioners and Physicians Assistants Training and Deployment Study, September 30, 1976 (pg. 51).

29. Ryser, J: PAs seen as asset in liability crisis. American Medical News. Chicago, American Medical Association, April 26, 1976.

30. Conant, O, Robertson, L, Kosa, J & Alpert, J: Anticipated patient acceptance of new nursing roles and physician assistants, The American Journal of Diseases in Children, 122: 202-205, 1971.

31. Nelson, E, Jacobs, A & Johnson, K: Patients' acceptance of physicians assistants, Journal of the American Medical Association, 228: 63-67, 1974.

32. U.S. Department of Health, Education and Welfare, Report of the Physician Extender Work Group, US Government Printing Office, Washington, D.C., June 1977.

33. Unpublished data. Association of Physician Assistant Programs: Physician Assistant: A Profile of the Profession, 1978.

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Carol Jo Shannon, R.D.H.

March 25, 1980

The Honorable Edward M. Kennedy
United States Senate
Subcommittee on Health and
Scientific Research
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Kennedy:

Attached is the record statement of the American Dental Hygienists' Association on S. 2144 and related matters.

We respectfully request that this letter, with its enclosures, be included on the record of the March, 1980 Subcommittee hearings.

Very Sincerely,

Jeri Yunker

Jeri Yunker, President
American Dental Hygienists' Association

JLY/cd

cc: Members of the Senate Labor and Human Resources
Subcommittee on Health

Enclosure 1

S.2144-HPEAA of 1980
(and other proposals)

Introduction

This statement of the American Dental Hygienists' Association is addressed to proposals outlined in S. 2144, "Health Professions Educational Assistance and Nurse Training Act of 1980", introduced in the Senate by Senator Richard Schweiker in December, 1979. When appropriate, reference will also be made to other legislative proposals advocated by the Administration, Senator Edward M. Kennedy and/or other sponsors. The Association statement will address health and manpower issues and programs that we have supported in both the federal and private sector for more than fifteen years. It is inconceivable that the fundamental principles which have been addressed in the various health professions educational assistance laws between 1963 and 1980 will either be modified beyond recognition or totally dropped.

Can we state as we enter the 1980's that every aspect of every problem associated with a high level of health care delivery has been resolved? It is not possible to have a viable national health care delivery system unless it can be assumed that (1) we have all of the health and allied health professions education schools we will ever need in place; (2) that we have all of the major categories of health and allied health care providers in the workforce; (3) that we have all categories of health practitioners in place as needed, in perfect distribution ratios to population needs; and (4) that state and local governments and private citizens are now able to absorb the major costs of operating all health professions teaching facilities. The federal subsidy providing many forms of educational assistance to schools and institutions over the past fifteen years has averaged about $1.3 billion annually.

Between 1965 and 1980 federal appropriations for health manpower programs have been substantial in the following categories:

Summary of Appropriations: 1965-1980

Type of Program	Total Amount Appropriated
MOD/VOPP: Institution & Student Financial Assistance	
1) Institution Grants (medical/dental schools, etc.)	$1,324,301,400
2) Student Financial Aid (medical/dental students, etc.)	866,122,000
3) Special Projects (medical/dental schools)	1,177,800,000
	$3,368,223,400
Dental Health Education (Division of Dentistry	108,490,000
Allied Health Education (Division of Associated Health Professionals)	290,905,000
Nurse Training (Division of Nursing)	1,299,982,000

Total Health Manpower* Expenditures $7,094,400,000

* Includes construction grants for teaching facilities, MOD/VOPP and Nursing.

"Health Professions Education Amendments of 1980"

Despite prior federal investments in health professions educational assistance as previously identified, it seems to us that the Administration's health manpower proposal, "Health Professions Education Amendments of 1980" represents a drastic departure from the principles of health manpower development in the past.

The Administration health manpower proposal is accompanied by an appropriations authorization table which is more illuminating on the basis of omissions than by inclusions for FY 1981 programs and beyond. It is clear that the Administration decision-makers for health manpower policies have the staff of the Office of Management and Budget, rather than from the ranks of health professionals of the Department of Health and Human Resources.

For example, the Administration proposes to:

- Repeal authorities for making capitation payments to various health professions schools;
- Repeal authorities for health professions facilities construction;
- Repeal start-up assistance authority;
- Repeal the general dentistry training authority;
- Remove incentives for unwarranted growth in the supply of health professionals; and
- Eliminate construction grants and start-up assistance.

The Administration's proposed appropriations authorizations would allocate the majority of the funds to medicine as follows:

. NHSC Program and Scholarships	$226.1 (53%)
. Family and General Medicine Projects	83.2 (20%)
. N.P & P.A. Training	25.5 (6%)
. Scholarships and Educational Assistance for the Disadvantaged	32.3 (7½%)
Subtotal:	$367.1 (86½%)

Dental Health Activities will receive less than five percent of the total health manpower budget. According to the Administration's priorities, dental health activities will be supported as follows:

. TEAM grants	$2.0 million
. NHSC Scholarships	8.32 "
. Loan repayments/cancellations	4.01 "
. Financial distress grants	2.2 "
. Exceptional Financial Need Scholarships	2.6 "
Subtotal:	$19.14 million
. Program Support Funds	.90 "
Total Dental Health Activities :	$20.4 million

If the Administration's "Health Professions Education Amendment of 1980" are approved, together with appropriation authorization levels recommended, dental health manpower will become all but extinct.

The American Dental Hygienists' Association believes that the Senate Human Resources Subcommittee on Health will conclude the Administration's health manpower proposal, "Health Professions Education Amendments of 1980" is unacceptable. The dental professions have maintained a constructive and beneficial partnership with Congress for sixteen years. The Administration's recommendations would, however, bring that relationship to an end. We urge the Subcommittee to reject the Administration's proposal and seek more reasonable solutions to the problems associated with the extension of P.L. 94-484 for another three years. In our view, the "Health Professions Educational Assistance and Nurse Training Act of 1980" (S.2144) and the "Health Professions Training and Distribution Act of 1980" (S.2375) represent a better starting point for dialogue between the health professions and Congress.

Health Professions Educational Assistance and Nurse Training Act of 1980

In its November, 1979 "Report on Allied Health Personnel" to Congress, the HEW Bureau of Health Manpower stated that, "dental hygienists are oral health clinicians and educators who help the public develop and maintain good oral health. As members of the dental health team, dental hygienists may perform preventive and therapeutic services under the supervision of the dentist". Although the majority of dental hygienists are employed by dentists in private practice, there are a growing number of graduates practicing dental hygiene in other settings such as, school systems, hospitals, clinics, state public health departments, etc.

The American Dental Hygienists' Association believes that we can provide improved access to dental care to underserved populations. It is basically from this vantage point that the Association hopes that its comments on S.2144 and S.2375 will be considered by the Subcommittee.

Senator Schweiker observed that S.2144 "provides considerable encouragement for individuals to practice their profession in underserved areas and to provide primary care, and for health professions schools to teach more about health promotion and disease prevention, about health care policy and economics, and about nutrition." The Association concurs with the Senator's views that a new health manpower legislative authority should address these aspects of health professions education and health care delivery.

Institutional Support Grants and National Priorities

There are still many unmet national goals and objectives which merit further federal support with respect to dental care, and not, as the Administration's bill suggests, abrupt termination. These unmet national goals in health manpower are concerned with the need to provide dental care to still unserved, large segments of the population.

Contrary to what the Administration and S.2144 recommend, the American Dental Hygienists' Association believes that health and allied health professions schools are still a necessary national resource. Their role in educating future dentists and dental hygienists will be critical in arresting dental disease. Institutional support grants for dental education institutions will be needed for sometime in the future if the existing educational institutions are to continue with their efforts. The Association joins with the American Dental Association and the American Association of Dental Schools in urging the Subcommittee to retain the institutional formula grant program for dental schools.

The Association also supports an ADA recommendation to Senator Schweiker that a separate authority for institutional grants to dental schools should be carefully considered. This recommendation includes the suggestion that a rationale for such federal support could be predicated on understandings between the dental schools and the federal government that the following educational initiatives would be undertaken to address national goals and concerns:

- Intramural and extramural studies and projects emphasizing prevention of dental diseases and nutrition and diet linkages to improved oral health care;
- Special courses and studies relating to improving access to dental care;
- Dental care cost containment studies and projects which would include effective utilization of dental hygienists in special intra- and extramural dental care clinics, improved practice management methods, and procedures and competency assurance assessments.

The Association is confident that dental and dental hygiene faculties are prepared and qualified to design and implement these new special emphasis studies and projects if a source of federal support is made available.

Special Project Grants

Although the Association is not in agreement with the provisions in S.2144 which would eliminate Institutional support (capitation) grants, we do agree that a major thrust of new health professions educational assistance authority should include a Special Projects rationale. ADHA is pleased that such an authority is proposed in S.2144 (Part C-Special Projects) and supports the concept that conditions should be imposed (Section 731(b)) to encourage educational institutions to provide instruction in health policy and health care ecomonics and to offer instruction in geriatrics, nutrition, disease prevention, etc.

The Association is particularly interested in the conditions stated in S.2144 (Section 731 (4) (A) & (B) and (C)) which would encourage dental schools to provide significant clinical training in underserved areas and in ambulatory settings which are geographically remote from the main site of school's teaching facilities.

The national goals stated in this section of the bill are in concert with the Association's goals and policies. We believe that dental hygiene programs produce manpower and a resource which is yet untapped in providing community dental health services where access to and availability of dental care can be improved. If dental hygienists are to be a fully participating member of the dental health team, traditionally trained and expanded function dental hygienists should be utilized more fully to close dental health care gaps.

The American Dental Association's recommendations on S.2144 express a preference for including an institutional formula grants program over special project grants such as TEAM and EFDA training. The American Dental Hygienists' Association believes that both institutional and project grants authorities will still be required in a new health manpower bill. In addition, we strongly recommend that separate authorizations be established for dental special projects, targeted to improve access to dental care and better distribution of dental personnel among special populations.

Although the ADHA would not object to the transfer of the TEAM (Institutional Grants Program) program, we strongly recommend that the EFDA grants program remain under Special Projects, in order to implement the "conditions" described in Section 731 (a) and (b) in S.2144.

The Association believes that Congress, the Public Health Services and the dental professions have additional options to consider in addressing the national dental health manpower problems. For example, while the Administration is recommending that approximately $8 million in 1981 health manpower funds be designated for NHSC scholarships, the ADHA suggests that these funds could, and perhaps should be designated as special projects targeted specifically for improving access to dental care in underserved geographical areas. The faculties of dental and dental hygiene schools, as well as members of the professions, could be tapped to tackle still unresolved access and distribution problems in the 18 states which are not now currently served by dental schools.

Bolstered by federal special project support funds, specifically authorized for preventive dental care education, training and service programs, national, state and local dental hygiene organizations and dental hygiene educators can be expected to apply both knowledge and expertise in a carefully focused effort to overcome distribution and access problems to which this statement and S.2144 are addressed.

Summary of ADHA Views and Recommendations

The American Dental Hygienists' Association is in complete agreement with the comments offered by Senator Edward M. Kennedy when the "Health Professions Training and Distribution Act of 1980" (S.2375) was introduced by Senator Bird on March 4. The goals of a national health care system, without reference to sponsors of any one such system, cannot be met unless there is an adequate supply of qualified health care providers. Maintaining the nation's health resources is the responsibility of the educational institutions, in a partnership with the federal government which has been nurtured over sixteen years. We believe that this long-standing and successful partnership between the federal government and the health professions schools should be continued and extended into the 1980's.

As this statement has tried to show, there are and will be still unmet national goals to be attained in the area of dental care in underserved population areas and among special population groups. Dental and dental hygiene schools and educators will play a prominent role in overcoming some of the still-remaining problems of access to dental care and distribution of dental personnel among the still unserved, special population groups. Dental and dental hygiene schools still need institutional and special project support to continue an educational emphasis on projects and studies which emphasize prevention of oral health disease, nutrition and diet, radiology health and safety, programs for special populations, competency assurance assessment mechanisms, and cost effective delivery systems.

The Special Project sections of both S.2144 and S.2375 identify the kinds of unfinished challenges remaining for the dental care community to address at the outset of the 1980's. The Association's views have been included at length in the foregoing statement and, in closing, are summarized below:

1. Federal incentives to increase the supply of dentists and dental hygienists are no longer needed.
2. Dental and dental hygiene schools, in the tradition of previous health manpower legislation, are a national resource and essential to maintain the supply of qualified dental health professionals.

3. Federal support for dental and dental hygiene schools is still needed to encourage educators and students to address still unsolved problems related to improving access to dental care and distribution of dental personnel among unserved segments of the population.

4. Separate legislative authorities and separate authorizations for dental programs be established for dental and dental auxiliary educational institutions as in prior years.

5. Dental hygienists are a key manpower resource available to the dental profession to assist in the task of increasing the productivity of the dental care team and to explore potentials for providing dental services to underserved special populations.

6. The Association believes that 167 dental hygiene schools located in non-dental school settings represent a source of untapped clinical facilities for providing dental care which can be developed into community dental health clinics.

7. The Association has concluded that both S.2144 and S.2375 can be modified to extend health manpower legislation for another three-year legislative cycle, beginning in 1981. However, the Association cannot support the "Health Professions Education Amendments of 1980" proposed by the Administration. ADHA believes that the Administration's health manpower bill does not offer substantive changes for improving the health professions educational systems and it fails to recommend a level of federal support to assist the schools in carrying out their educational missions for even one more year.

Enclosure 2

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

Comments on Health Professions Educational Assistance and Nurse Training Amendments of 1980 (H.R. 6802)

"Title I - National Health Service Corps Programs"

Section 102. Revision of National Health Service Corps Scholarship Program

Comments

The Association strongly urges the subcommittee to consider students in dental hygiene baccalaureate and master's degree programs as eligible to apply for NHSC scholarships. According to the *Federal Register*'s notice of March 12, 1980, page 16012, baccalaureate and master's degree nursing students have been added to the list of eligible candidates to receive scholarships (sect. 751 of the PHS Act) and, from the standpoint of the dental care delivery system, similarly credentialed dental hygienists should be considered to assure an adequate supply of dental professionals.

"Title II - Health Professions Programs Under Title VII"

Part C - Section 770. Institutional Support Grants

Comments

The Association's views on providing institutional support grants for dental schools are stated at length in Enclosure 2 of the cover letter. As noted in our statement transmitted to the Senate Human Resources Subcommittee, ADHA is opposed to the termination of institutional educational assistance grants at this time, as proposed in H.R. 6800 and S.2144. The authorization levels recommended in Section 770 (d) (3) in H.R. 6802 for FY 1981-1983 appear to represent reasonable appropriations' targets for the dental educational institutions to maintain the quality of their curriculums and faculties as established under previous health manpower legislation. Also, the Association concurs with the sponsors of H.R. 6802 that annual enrollment increases, as a means test for eligibility for federal assistance, are no longer necessary.

Part D - Section 217 Project Grants and Contracts; Physician Assistants and Dental Auxiliaries

Comments

The Association has supported the inclusion of EFDA grants in previous health manpower laws and firmly believes that this title of a new law should be retained as it is in H.R. 6802. However, in view of the Comptroller General's Report on "Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists and Tax Payers", March 71, 1980, the Subcommittee may wish to consider the necessity for establishing a separate authorization for EFDA training. If Congress determines that the Comptroller General's recommendations should be implemanted within the federally funded dental care delivery system, EFDA training programs will become significantly more important in th overall effort to improve the efficiency of the dental component of the nation's health care delivery system. The Association recommends that authorizations for EFDA training programs be as follows: $5,000,000 for the fiscal year ending September 30, 1981; $6,000,000 for the fiscal year ending September 30, 1982; and $7,000,000 for the fiscal year ending September 30, 1983. In addition, the Association urges that the EFDA grants program be funded separately from the Physician Assistants grants program to more clearly reflect the intent of Congress.

Section 794. Midcareer Training and Education

Comments

The Association supports this section of H.R. 6802 which it recognizes as an innovative health manpower concept that logically arises from previous health manpower program initiatives. If implemented, the Association urges the Subcommittee to include allied health training centers as possible sites in which advanced training in health systems financial management and health care strategies could be offered.

Section 794 C. Grants to Departments of Preventive or Community Medicine or Dentistry

Comments

The Association supports the intent of the sponsors of H.R. 6802 to provide incentives for dental and medical schools to establish departments of preventive dentistry and medicine to coordinate pre-doctoral and post-doctoral courses. While many of the schools have already established preventive and community health departments in their curriculums, the coordination and integration of preventive approaches to health care do need to be interwoven with instruction offered in other major departments. Since dental hygiene education is primarily prevention oriented, dental hygiene departments of dental schools will be an important resource for the dental educators to utilize in designing new programs to qualify for assistance under Section 794 C.

The American Dental Hygienists' Association supports the proposal to establish preventive and community dental health departments in dental schools and recommends that the authorizations for this special project program outlined in H.R. 6802 be increased to $4,000,000, $5,000,000, and $6,000,000 in FY 1981, 1982 and 1983. It is further recommended that these sums be divided equally between dental and medical schools on a first-come, first-served basis.

Part F - Allied Health Personnel. Section 235, Project Grants and Section 236, Traineeships

Comments

The Association, as one of the allied health professions designated in the original Allied Health Professions Personnel Training Act of

1966 (P.L. 89-751), strongly supports the continued inclusion of an allied health authority in the amendments to P.L. 94-484. Despite efforts of the Executive Branch in recent years to terminate this program, ADHA does not believe that the need for continued support of allied health training centers and programs has diminished. Among the health manpower proposals now being considered in Congress, only H.R. 6800, the Administration bill, does not recognize the necessity of providing continued support for allied health educational institutions. We urge the House Commerce Subcommittee on Health to hold firm in its intention to support allied health education and training at least at the levels proposed in Sections 235 and 236 of H.R. 6802. While this level of support does not seem to be adequate to meet the needs for federal support of the schools of allied health, the Association recognizes the severity of pressures currently to stay within the Congressional budgetary limits which are still under consideration.

TESTIMONY FOR THE RECORD OF

THE AMERICAN ASSOCIATION OF
NURSE ANESTHETISTS

Before The

SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

Re:

THE NURSE TRAINING ACT - 1980 AMENDMENTS

April 1980

The American Association of Nurse Anesthetists ("AANA") is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists ("CRNAs"). There are presently 15,000 active practicing CRNAs in the United States. Each one of these individuals holds unique qualifications which allow them to administer anesthesia. AANA submits that in the absence of an anesthesiologist, or a physician anesthetist with a significant background in anesthesia, that the CRNA possesses the necessary knowledge, skill and educational background to be involved in the assessment, management and administration of a patient's anesthesia requirements under the medical direction of a responsible physician. For individuals to represent themselves to the public as CRNAs, they must hold a current license as a registered professional nurse, have graduated from an accredited program of nurse anesthesia, have passed a rigid qualifying examination, and must be involved in a program of continuing education in anesthesia.

We are interested in legislation to extend the authority for the nurse anesthetist traineeship program in the Nurse Training Act. That program is in the Nurse Training Act Amendments of 1979, authorized for FY 1980 only at an authorization level of $2 million. HEW has requested $1 million for FY 1980 and $1 million for FY 1981 in its budget. The $1 million for FY 1980 was to be accomplished by a transfer of funds but that must be approved by the Appropriations Committee which has not acted yet on a supplemental for FY 1980 nor on the FY 1981 bill. The $1 million budget request will support 75 grants and 230 traineeships at an average traineeship of $4,300. S. 2375 includes a 3-year extension of the authority levels of

$2 million. We support the extension but prefer the authoriation levels in H.R. 6802 of $2 million, $3 million and $4 million.

We would now like to address ourselves to the provisions relating to nurse anesthetist training.

1. The Educational Program and Training of a Nurse Anesthetist

As this testimony will point out, the CRNA is a much needed element within the health care system. To understand the type of educational program the CRNA must complete (and the type of program for which we are requesting Federal support), allow me to delineate the current educational requirements for CRNAs. Building on the professional nursing base, the student nurse anesthetist must complete the following program: Orientation to Anesthesia Practice - 45 contact hours; Chemistry and Physics of Anesthesia - 45 contact hours; Advanced Anatomy, Physiology and Pathophysiology - 120 contact hours; Principles of Anesthetic Management - 60 contact hours; Pharmacology of Anesthetic, Adjunctive and Ancillary Drugs - 60 contact hours; and Clinical Correlative Conferences - 35 contact hours. Also included in the clinical program is a requirement of a minimum of 600 hours of actual anesthesia time in which clinical instruction is provided in situations where students actually administer the anesthesia. Other requirements include a minimum of 450 cases of anesthesia actually administered with these cases distributed according to types of techniques required and variety of drugs used. With this type of background, there should be no doubt as to the ability of the CRNA to provide the patient with quality anesthesia care.

Training programs are graduate-level programs for registered nurses. Training involves 18 to 24 consecutive months of course work and clinical instruction and a certificate of graduation is received when the program is successfully completed. All training programs are accredited by an accreditation body approved by the Office of Education. There are presently 165 of such programs while there were 225.

2. The Dimensions of Nurse Anesthetist Practice

As previously stated, the CRNA is a vital element within the health care system in the United States. Nationwide, nurse anesthetists are providing safe, reliable and economic anesthesia care to approximately one-half of all of the patients undergoing anesthesia. Included in this statistic is the fact that in rural areas nurse anesthetists account for approximately two-thirds of all anesthesia care rendered. Throughout many areas in the country, nurse anesthetists are the only providers of anesthesia care. (In a 1971 survey of hospitals, forty percent of all of the hospitals surveyed had only nurse anesthetists on the staff.) According to figures published in the February, 1978 issue of Anesthesiology, the national mean population ratio for active practicing nurse anesthetists is 7.20 per 100,000. This figure compares with a distribution of 4.64 anesthesiologists per 100,000. A breakdown of these figures on a regional basis will show that the areas with the thinnest distribution of anesthesiologists have the highest distribution patterns for nurse anesthetists.

3. Supply and Need for Nurse Anesthetists

Not only are CRNAs a vital segment of the health care system within the United States, there is a definite projected need for more nurse anesthetists in the future. According to a 1976 study by the H.E.W. Bureau of Health Manpower on "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the United States, 1972 and 1980" (HRA:77-31), there is a projected need of from 22,000 to 25,000 nurse anesthetists for 1980. Obviously, there is a serious shortage in this field which provides approximately half of all anesthesia services in the United States. Inclusion of the traineeships for students in schools of nurse anesthesia in the Nurse Training Amendments of 1979 will be the first step on the part of the Federal Government to rectify this shortage.

The fact that nurse anesthetists are a significant group in delivery of anesthesia services was pointed out by Dr. Feldstein of the University of Michigan in a study of the 16,500,000 surgical procedures performed in 1974. The largest percentage of anesthetics administered, 48.5%, was rendered by CRNAs; 38.3% was rendered by anesthesiologists, including both board-certified and non-board-certified; 9.7% by physicians other than anesthesiologists; and 3.5% by registered nurses other than CRNAs. A further breakdown of those procedures indicates that certified registered anesthetists administered approximately two-thirds of all the anesthesia procedures in hosptials smaller than 100 beds. Anesthesiologists tend to congregate in larger hospitals, over 200 beds, where they administered 47.5% of all anesthesia compared to 42.5% for Certified Registered Nurse Anesthetists.

4. Economics of Nurse Anesthetist Services

The majority of nurse anesthetists are salaried hospital staff, whose services are billed by the hospital as part of hospital operating room costs. According to the U.S. Department of Labor, Bureau of Labor Statistics, "Industry Wage Survey of Hospitals, August, 1975 - January, 1976", the average hourly wage for nurse anesthetists working in 21 major metropolitan areas was $8.02. Based on a 40-hour work week, the average annual earnings for a nurse anesthetist would be $16,681.60. This figure compares with full-time equivalency earnings of hospital-based anesthesiologists of $80,000 as determined by a Health Care Financing Administration "Study of the Reimbursement and Practice Arrangements of Provider-Based Physicians, December, 1977" (Contract No. 600-76-0055). An analysis of these two salary figures indicates that where nurse anesthetists are providing anesthesia services, the cost to the patient should be substantially lower than where anesthesiologists are providing the services. Even where a team approach is used, the fact that some of the time utilised is of CRNAs rather than anesthesiologists would indicate efficiency and cost savings.

5. Need for Federal Training Support

Nurse anesthetists are clearly a shortage field in health care. Possibly twice as many nurse anesthetists are needed for 1980 as are practicing now according to the HEW study cited above.

One of the obstacles to obtaining them is the lack of financial support for trainees. Training programs are generally for two years; a substantial graduate program. (Stipends for research careers are, for example, $10,000 to $13,000.) The total of tuition and all costs is, at a minimum, now $6,000 to these living and educational costs of $6,000 to $8,000. Limited resources prevent institutions from offering more aid or from offering aid to more students. Federal support to the institutions for traineeships will allow a greater number of students to enter programs since some programs are prevented from expending due to the lack of stipend money. It will also relieve the burden on low income students to permit their entry into the program. In addition, with the Federal Government picking up some of the traineeship costs, institutions will be able to devote some of their future funding to program expansion.

It should be noted that the number of nurse anesthetist training programs has decreased by about 60. These were the smaller programs. Federal support may prevent such harmful attrition and stimulate the development of new programs.

With respect to operating costs of nurse anesthetist training programs, patient care hospital revenues support such activity as staff, supplies and teaching space. We note with satisfaction, that such costs of hospitals are excluded from the recent hospital cost containment legislation offered by Senators Talmadge and Dole.

We appreciate the opportunity to testify and your Subcommittee's attention to this matter.

$8,000 per year to the student with living costs for an individual very near that. Tuition costs range considerably with some at $2,000 to $2,500 and others only nominal with the hospital assuming all costs. Hospitals also offer stipends but the average is about $3,000. With hospitals attempting to limit costs and inflation rampant, hospitals are able to devote less to these programs than in prior years. Many hospitals have dropped their programs entirely; the number has decreased from 235 to 165 in recent years. Students are generally unable to hold part-time jobs because the nurse anesthesia program runs for 18 to 24 consecutive months. In addition, rotating clinical schedules prevent prat-time work in the evenings and on weekends. The finanicial problems mentioned above deter students from entering this field. Loans are difficult to obtain and entry level salaries are in the $15,000 range with average salaries after 5 years at $20,000. Such salary levels are not conducive to borrowing particularly if an individual has a family to support.

Traineeship support authorized at $2 million, $3 million and $4 million would assist in meeting the needs of this program. The hospital training programs are not eligible under the Higher Education Act for any student aid because they are not in nursing colleges nor diploma schools of nursing. Thus, assistance is particularly important.

To the institution, the major financial burden is in making stipends available to students. With living costs what they are and not time for part-time work, stipends are critical. Institutions put up $3,000 on the average toward

AAP ASSOCIATION for the ADVANCEMENT of PSYCHOLOGY

March 13, 1980

The Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The enclosed statement outlines the need for recognizing psychology as one of the health professions which should be served by the Health Professions Educational Assistance Act, which is presently being considered for renewed authorization.

The Health Professions Educational Assistance Act has been a significant force in remedying shortages of health personnel, in promoting programs to assuage their maldistribution, and in developing innovative and cost-effective approaches to training and utilizing health care personnel.

Psychologists represent the largest group of doctorally-trained mental health care providers in America. Psychologists are becoming increasingly involved in managing the behavioral aspects of health and medical care. Yet of the four core mental health professions -- psychology, psychiatry, social work and mental health nursing -- psychology is the only one that has not yet been recognized as a "health" profession in this Act.

Federal funds for supporting and stimulating training programs in psychology come only from the Alcohol, Drug Abuse and Mental Health Administration. The other mental health disciplines receive directed funding from ADAHMA as well, but these funds are complemented by the broader-based professional development support that the Health Resources Administration offers under this Act.

There are several areas of need which are reported in detail in the enclosed report.

In a report prepared for HEW to study mental health illness of the elderly, it is estimated that 2,000 clinical psychologists must be trained by 1988 to serve the mental health needs of the elderly. There is a current shortage of at least 2,000 psychologists to work with this population, and another 3,000 to 5,000 should be trained over the next decade. (Another 18,000 to 22,000 trained individuals in the other core mental health professions will be needed as well.) (pp. 5-7)

March 13, 1980
Page Two

There is an obvious shortage of clinical child psychologists. We estimate that there is a current shortage of 5,000 fully trained clinical child psychologists, and that another 5,000 such psychologists should be trained over the next decade. (pp. 7-9)

Minority populations will increase at significantly higher rates than the anglo-white population, which is expected to expand by only 18.3% between 1976 and 2000. These trends will exacerbate the current under-representation of ethnic minorities among providers of psychological services. (pp. 9-11)

The need for clinical neuropsychologists is great. Estimates of the number of additional clinical neuropsychologists needed today vary greatly, from 1,500 to 12,000. It seems reasonable to say that 3,000 individuals should be produced over the next decade. (pp. 11-13)

We believe that the public need for these services can only be met by placing psychology amongst the professions served by the Health Professions Educational Assistance Act.

If you need any additional information, we will be pleased to provide you with it.

Sincerely,

Clarence Martin

Clarence J. Martin
Executive Director and
General Counsel

CJM:slm
Enc.

cc: Robert Knouss

The President's Commission on Mental Health precisely defined the need to support the mental health professions under the Health Professions Education Act.

> The quality of mental health care depends ultimately on the knowledge, skills, and sensitivity of those providing it. We can build a network of comprehensive services and provide people with the means to pay for the services but accomplish little in the absence of skilled personnel to meet the diverse needs of those requiring care.
>
> In its preface to the Health Professions Educational Assistance Act of 1976, the Congress stated that "...the Federal Government shares the responsibility of assuring ...[that] qualified personnel are available to meet the health care needs of the American people. It is, therefore, appropriate to provide for the education and training of such personnel..."
>
> The Commission concurs with this statement and believes it has special relevance for mental health.
>
> Since the establishment of the National Institutes of Mental Health in 1946, the policy of the Federal Government with respect to mental health personnel has been to increase the number of qualified specialists. Implicit in this policy was the assumption that an increase in numbers would help to assure that all Americans had access to needed care. This assumption has not proved to be correct.
>
> There has been a marked increase in the number of professional and paraprofessional mental health practitioners. However, rural areas, small towns, and poor urban areas still have only a fraction of the personnel they need. Many mental health facilities have a shortage of trained personnel. The mental health professions still have too few minority members. There is a shortage of specialists trained to work with children, adolescents, and the elderly.
>
> If these problems are to be addressed during the next decade, Federal mental health personnel must be redirected. We believe the three major objectives of a new policy should be to:
>
> --encourage mental health specialists to work in areas and settings where severe shortages exist;
>
> --increase the number of qualified minority personnel in the mental health professions, and the number of mental health personnel trained to deal with the special problems of children, adolescents, and the elderly; and
>
> --assure that the skills and knowledge of mental health personnel are appropriate to the needs of those they serve.
>
> Since 1969, Federal support for mental health personnel has been steadily reduced and some have urged that it be phased out. In our opinion, these problems, affecting as

> they do the poor, minorities, the rural population, children, the elderly, and those dependent upon public facilities, cannot be solved without Federal support. Sufficient resources must be assured in the transition period and in the future.
>
> (Report to the President from the President's Commission on Mental Health, Vol. I, p. 35.)

The Health Professions Educational Assistance Act has been a significant force in remedying shortages of health personnel, in promoting programs to assuage their maldistribution, and in developing innovative and cost-effective approaches to training and utilizing health care personnel.

Psychologists represent the largest group of doctorally-trained mental health care providers in America. Psychologists are becoming increasingly involved in managing the behavioral aspects of health and medical care. Yet of the four core mental health professions -- psychology, psychiatry, social work and mental health nursing -- psychology is the only one that has not yet been recognized as a "health" profession in this Act.

Federal funds for supporting and stimulating training programs in psychology come only from the Alcohol, Drug Abuse and Mental Health Administration. The other mental health disciplines receive directed funding from ADAHMA as well, but these funds are complemented by the broader-based professional development support that the Health Resources Administration offers under this Act.

The President's Commission reported that, depending on the definition of emotional disorder used, the available evidence suggests that in any given year 15% of the population, or 34 million individuals, are in need of some type of mental health service. However, only about 3% of the population actually receives specialized mental health services in a given year, a figure of about 7 million citizens. Only 12% of the nation's annual health expenditures are utilized on mental health services (PCMH, 1978). The difference between those in need of mental health services and those receiving mental health services is obviously great.

All of the four core mental health professions, as well as paraprofessionals, must be included in the system in order to reflect current reality and realistic quality of care. Psychiatrists need to be included so as to insure medical expertise, when necessary, and knowledge about and potential use of medication. Psychologists need to be included in order to insure appropriate consideration of psychological and behavioral perspectives, and an empirical/objective/comparative approach to the assessment and consideration of alternative interventions. Social workers, and nurses with mental health training, would be included to address relevant aspects of families, social settings, and systems of care. Paraprofessionals are an important component of the system since such individuals sometimes represent unique approaches to and perspectives about various patients and problems.

Again, we must note that the present and proposed bills cover all these components except psychology.

The difference between 15% of the population needing mental health services and only 3% receiving them indicates the overall need for additional psychologists and other mental health providers. First, we will present the data on the current supply of additional psychologists by reviewing the service needs of the elderly, children and youth, and minorities, as well as considering the need for several specific services.

Psychology in general and clinical psychology in particular have experienced substantial growth in the last 30 years. Areas of applied psychology, particularly those related to physical health care, have shown an even more recent growth spurt. The public has the most up-to-date conceptualization of professional psychology through its use of psychological services. Approximately 3 million patients receive 19 million hours of psychological services annually.

Nonetheless, psychology in general and professional psychology in particular have had continuing difficulty in getting relevant federal agencies to collect data on psychologists. In some cases data are not collected at all. In other situations, data on doctoral level psychologists are grouped in the same category with data on program aides who happen to have bachelor's degrees in psychology. However, data do exist on the training, licensing, location, and activities of psychologists. The information comes from a variety of sources: periodic surveys of APA members, surveys of all licensed or certified psychologists in the United States, analyses of APA membership, and independently conducted surveys.

Current Supply of Psychologists Health Service Providers

The data on psychologists collected by the National Institute of Mental Health at the present time do not allow one to make an overall estimate of the number of psychologist providers. The National Center for Health Statistics does not collect data on psychologists at this time. However, NCHS has agreed to do so in the future. An initial version of the questionnaire to be sent to psychologists through the Cooperative Health Statistics Network has been developed by a joint NIMH/NCHS work group, with the participation of organized psychology.

The National Register survey (Mills, [illegible] and VandenBos, 1979) was the first survey of all licensed or certified psychologists in the United States. An unduplicated roster of 25,510 licensed/certified psychologists was developed. This was the first unduplicated count of licensed and certified psychologists. The entire population was surveyed with a 36-item questionnaire asking for information about training, practice location, income and type of patients seen. A response rate of 74% was obtained. From this data the authors estimated that there were 22,588 psychologists trained and licensed as health service providers in early 1977. However not all individuals trained and licensed as providers were active in the provision of service. They found that 18,882 of the licensed/certified and appropriately qualified individuals were in fact active in the provision of health services. Of these, 14,199 were involved to some extent in private practice providing psychological services, but only 4,683 were involved in full-time private practice.

Data on the unemployment of psychology doctorates gives a perspective on the demand for psychologists. Such data are collected independently by two sources: the National Academy of Sciences and the American Psychological Association. The National Academy of Sciences' surveys are based on a roster of Ph.D.'s in science, engineering, and the humanities. The American Pyschological Association surveys new doctorates in the winter following the receipt of their degree.

The National Academy of Sciences' report (1978) shows the employment status of Ph.D.s in psychology to be very good. The unemployment rate in 1973 was 1.1%;

in 1975 it was .8%, and in 1977 it was 1.2%. According to Academy employment data on all doctoral level scientists and engineers who received doctorates between 1971 and 1976, the unemployment rate for all doctorate level psychologists was 1.9%. The latest data from the American Psychological Association on the employment status of recent doctoral recipients in psychology is from a survey of the 1977 graduates. Of the 1,123 psychologists receiving doctoral degrees in service specialities that year, only 18 reported being unemployed and seeking employment. This is an unemployment figure of 0.6%.

Psychologists provide over one third of a million clinical hours of service per week; between 1.1 million and 4.5 million patients are seen by doctoral level APA-member psychologists in a given year. Kiesler, Cummings and VandenBos (1979) suggest that the best estimate is about 3 million patients are seen each year by psychologist health care providers and over 19 million hours of service are provided each year. Only 20% of health service provider psychologists are full-time private practice providers of mental health services, and the majority of psychologist providers are employed full-time in public agencies and provide additional mental health services on an independent fee-for-service basis part-time.

Ninety-five percent of the doctoral level health service providers are white. Thus, in 1977 less than 5% were ethnic minorities. Data from the Survey of Earned Doctorates conducted by the National Academy of Sciences showed that 7% of the persons earning their doctorate in psychology in 1976-77 were ethnic minorities. A 1976-77 APA survey of 103 graduate departments with APA-approved clinical psychology programs found that 10.7% of the students were ethnic minorities, and that the subsample of 25 graduate departments involved with the APA minority fellowship program had 15.1% ethnic minority students. These figures suggest that progress is being made, but it will obviously take some time for those in the training "pipeline" to empty into the professional market with sufficient impact. Provided the national policy and priorities continue to support these efforts, significant positive effects will be clearly demonstrable within the next 10 to 15 years. Continued federal commitment is obviously critical.

Seventy-six percent of the doctoral level health service providers are male. Thus, in 1977 about 24% of health service psychologists were female. Data from the Survey of Earned Doctorates conducted by the National Academy of Sciences showed that 36% of the persons earning their doctorate in psychology in 1976-77 were women. A 1976-77 APA survey of 103 graduate departments with APA-approved clinical psychology programs found that 46% of the students were women. These figures suggest that equality of opportunity for training in psychology has essentially been achieved. The present problem for female professionals in psychology is equality of promotional opportunities. The problem of inappropriate mental health treatment provided to women is caused by a lack of curriculum material on women's issues, both in core psychological training and continuing education. These latter problems must be addressed.

Professional psychology is a relatively young profession. The median age of health service provider psychologists is 45. To this point in time there has been little natural attrition through retirement and death. However, over the next 10 years there will be a need to offset such natural attrition. This fact of professional training is already recognized and incorporated in the training of psychiatrists and social workers, but it needs to be built into the training of psychologists. Since it takes 5 to 6 years to train a psychologist, it is imperative to increase the training of psychologists to offset the

the future attrition rates due to retirement and age. Seventeen percent of psychologists are in the age range of 50 to 54, and another 16% in the age range from 55 to 64. Thus over the next 3 to 8 years, we will need some 300 to 400 additional doctoral health service provider psychologists annually to replace those retiring, and within 10 years it will be necessary to train some 800 to 900 psychologists annually to offset the natural attrition rate.

Mental Health Needs of the Elderly and as an Example of Mental Health Personnel Shortages

Current estimates suggest that there are approximately 23 million persons of age 65 or older in the United States, or about 11% of the current population. Of these, it is estimated by several reviews of existing studies (e.g., Gatz, Smyer, and Lawton, in press) that between 18 and 25 percent of the elderly have significant mental health problems that warrant professional help. Supporting evidence for this estimate comes from a recent national survey (Douvan, Kulka, and Veroff, 1978) in which 19% of respondents age 65 and older felt that they could use professional mental health assistance. If one takes 20% as a rough estimate of the proportion of the elderly needing mental health assistance, then it can be assumed that there are at least 4.5 million elderly Americans whose mental health needs are serious enough to require professional assistance.

While the elderly are one of the several populations which manifest mental health needs above the national average for such difficulties, they receive markedly less care. Several task panels of the President's Commission on Mental Health observed that although the elderly account for 11% of the population *and* are known to have greater mental health needs proportionately, they constituted only 4% of the cases handled by community mental health centers in recent years. Moreover, the elderly account for an even smaller proportion of cases handled by private practitioners in mental health, with estimates ranging from 0.6% to 2% of private cases. It has been estimated that in 1980 approximately 85% of those over age 65 who are in need of mental health services will not be receiving such services (Kramer, Taube, and Redick, 1973). The mental health needs of the elderly in the United States are massive and inadequately served.

As great as the current mental health needs of the elderly are, they will almost inevitably become even greater in magnitude as the age distribution of the U.S. population shifts upward in the coming decades. It is estimated that by the year 2000 there will be at least 30 million persons over age 65. Assuming that the proportion of elderly requiring mental health services does no worse than remain constant at approximately 20%, we can estimate that at least 6 million elderly will be in need of professional assistance by the year 2000.

What are the specific major mental health problems of the elderly? Any such list must of necessity be both oversimplified and incomplete. Issues prominent in most analyses are the following: (1) Senility or senile dementia: often mentioned as the mental health problem most feared by the elderly. It is, nevertheless, probably overdiagnosed. Robert Butler, Director of the National Institute on Aging, states that there are "over 100 reversible syndromes that may mimic senile dementia' (PCMH, 1978). (2) Depression: occasionally misdiagnosed as senility, depression may be either caused or greatly exacerbated by the many complex stresses in life situations that affect the elderly, including "social role changes, personal losses that lead to bereavements, retirement from jobs, drop in income, economic worries, isolation, fear of crime, and concerns about health prospects" (PCMH, 1978). (3) Suicide: disproportionately high among the elderly, especially males (the elderly account for 25% of all reported suicides). (4) Alcoholism: it is estimated that perhaps as high as

30 to 40 percent of the elderly have alcoholism problems, often developed late in life, which need treatment. (5) Sleep problems: may result from an interaction of physical conditions and the sorts of stresses mentioned above. (6) Behavioral consequences of drugs: the elderly utilize 25% of all medications prescribed, and the interaction of various medications (perhaps resulting from consulting several different physicians) can result in difficult psychological or behavioral problems.

In all of the above problems there is the possibility of a psychological or behavioral "cause" at the root of the symptom, and certainly medical, pharmacological, and nutritional causes as well. These problems require the expertise of appropriately trained personnel. The unique contribution of a psychologist is sensitivity to the predisposing or root causes underlying the problem that are not biological in nature, but rather may be behavioral, psychological, social, or even economic in origin. The strengths and the skills of psychologists can act as a partial check on the inappropriate diagnosis and treatment of problems as essentially medical problems in isolation from other factors. Training which focuses on the understanding of the individual in the context of his/her life situation and personal environment allows the psychologist to provide mental health services to the elderly by means of psychological assessment, psychotherapy, and consultation. More specifically, with regard to treatment, psychologists contribute to the optimizing of personal autonomy and integrity by teaching coping skills, providing counseling around predictable life crises, maximizing the fit between individual and environment by means of environmental design, and by identifying social-economic system factors which exacerbate mental disorders (Gatz, Smyer, and Lawton, in press).

In the face of this massive need, what can we say about the supply of psychologists who are prepared to provide services to the elderly? Reliable estimates are severly hampered by the total lack of definitive data, and the relative lack of data of even the crudest sort. A survey of the 25,510 licensed/certified psychologists listed in the *National Register of Health Service Providers in Psychology* found only 28 persons who "specialized" in services to the elderly, using the criterion that 76% or more of one's clients were age 65 or older (Mills, Wellner, and VandenBos, 1979). Other recent studies suggest there are only about 100 clinical psychologists with intensive specialized formal training in the clinical psychology of aging (Storandt, 1978), and that probably less than 400 clinical psychologists are currently spending the majority of their clinical time with the elderly (Dye, 1978). In some respects these figures are not surprising, particularly from an economic perspective. Elderly patients in general have limited incomes and depend on Medicare to assist them with health costs. Medicare, however, both severely limits mental health benefits and excludes psychologists as direct providers. Professionals do not specialize in areas where they cannot receive payment. The number of psychologists specializing in the provision of services to the elderly is, nonetheless, very small, and woefully small when compared to the magnitude of the need. A larger but unknown number of psychologists treat some proportion of elderly persons, but the overwhelming majority of them were trained in a more generalist fashion and did not receive specific training in treating the elderly.

THE MAGNITUDE OF THE SUPPLY SHORTFALL CAUSED BIRREN AND SLOANE (1977), IN A REPORT PREPARED FOR THE HEW COMMITTEE TO STUDY MENTAL HEALTH ILLNESS OF THE ELDERLY, TO ESTIMATE THAT 2,000 CLINICAL PSYCHOLOGISTS MUST BE TRAINED BY 1988 TO SERVE THE MENTAL HEALTH NEEDS OF THE ELDERLY. BIRREN AND SLOANE ACKNOWLEDGE THAT THEIR ESTIMATE OF THE NUMBER OF PSYCHOLOGISTS NEEDED IS LOW (AND THEY USED ONLY A 10% NEED FIGURE). THERE IS A *CURRENT* SHORTAGE OF AT LEAST 2,000 PSYCHO-

LOGISTS TO WORK WITH THIS POPULATION, AND ANOTHER 3,000 TO 5,000 SHOULD BE TRAINED OVER THE NEXT DECADE. (ANOTHER 18,000 TO 22,000 TRAINED INDIVIDUALS IN THE OTHER CORE MENTAL HEALTH PROFESSIONS WILL BE NEEDED.)

In public testimony in May 1978, before the Subcommittee on Human Services, and the Subcommittee on Health and Long Term Care of the House Select Committee on Aging, psychologist Dr. Ilene Siegler of Duke University's Center for the Study of Aging and Human Development suggested a number of specific mechanisms by which the federal government could promote the education and training of psychologists in the area of aging. These include: (1) curriculum development projects, including curriculum materials; (2) institutional training grants tar- geted to training psychologists in the provision of mental health services to the elderly; (3) development of internship programs in aging, particularly emphasizing predoctoral practicum experience opportunities; (4) teaching grants to departments of psychology, perhaps aimed at the undergraduate levels as well as graduate; (5) support of continuing education programs for upgrading of skills or retraining in mid-career; and (6) programs to identify and recruit young persons with an interest in gerontology, perhaps through summer programs at the undergraduate and even high school level.

Mental Health Needs of Children and Youth as an Example of Mental Health Personnel Shortages

Recent census serveys report that there are in excess of 64 million children who are seventeen or younger. In younger children, classic psychiatric symptoms such as depression, anxiety reactions, and conversion reactions occur, but are rare. Rather, the symptoms of psychopathology in young children tends to be in the form of behavioral problems, learning problems, and developmental delays. Between 300,00 and 750,000 children annually have problems with encopresis, and 3 million children are enuretic. Between 1.4 and 3.5 million elementary school children are hyperactive, with social and behavioral difficulties. It is esti- mated that about 10% of all children experience some degree of brain damage, and that about half of these will later manifest learning and behavioral diffi- culties. Between 10% and 14% of all hospital beds are occupied by children, and the experience of being hospitalized is stressful and can produce lasting emotional and behavioral disturbance. Between 400,00 and 600,00 children under the age of five are accidentally poisoned each year. One out of every 4 children who are accidentally poisoned will later be re-treated for poisoning. This re- currence incidence suggests the need for an analysis of the behavioral basis of the "poisoned" symptom (Wright, Schaefer, and Solomons, 1979).

Most traditional mental health symptoms begin appearing during the adolescent years. In addition, behavior disorders and/or adjustment reactions are frequent during the teenage years. Eleven percent of psychiatric admissions for children under the age of 16 are for suidical attempts, and 50% of all adolescents who attempt suicide will do so two or more times. Analysis of the lives of teenagers who attempt suicide reveals major interpersonal difficulties, behavioral problems, and psychopathology. Drug abuse and alcoholism are frequent among adolescents. This suggests a self-medication process since we know that the majority of ado- lescent adjustment reactions involve affective disturbances. Juvenile delinquency, school problems, and difficulties involving sexuality are also, in part, related to psychological problems.

There are many specific characteristics of the social stress situation and social conditions of children and youth which mandate the necessity for increased availability of psychological services. These characteristics include:

(1) the fact that 7% of all children under 6 have parents who both work; (2) almost a million divorces occur annually, involving up to 1.2 million children; (3) the incidence of of child abuse has been projected to be between 200,000 and 500,000 cases; (4) almost 300,000 children live in foster homes; (5) between 250,000 and 300,000 children live in public and private residential institutions; (6) approximately 150,000 children live in detention centers and training schools for delinquents; (7) at least 95,000 children and adolescents live in residential hospitals for the mentally retarded; (8) 78,000 children are in residential treatment centers for the emotionally disturbed; (9) 15,000 adolescents live independently; and (10) through the evaluation processes mandated by P.L. 94-142 over a million handicapped children in the public schools have been identified as needing special school and mental health services.

The President's Commission on Mental Health (1978) has documented the fact, as did the Joint Commission on the Mental Health of Children in 1965, that all children in these situations are underserved and that troubled children and adolescents, especially if they are from racial minorities, are often left to struggle without a mental health system staffed by persons specially trained to address their needs in institutions, special schools, or foster homes. The Commission made specific recommendations regarding the training of specialists to serve children and adolescents. The Commission reported that while children and adolescents comprise, along with the elderly, over half the nation's population, they receive the fewest mental health services. The Commission further recognized the importance of cultural, socio-economic, behavioral and psychological factors during early life stages, and recommended that training programs be made increasingly available to allow professionals to confront these aspects of mental health functioning.

The nature of psychological mental health service needs of children are many and varied: pediatric psychological interventions, early socialization needs, learning difficulteis, behavioral problems, impulse control issues, family and social interaction problems, as well as traditional mental health problems. Mental health-related problems, as is true of physical health-based problems, must also be addressed by emphasizing the role of prevention in the strategy to combat these problems. The President's Commission on Mental Health has recognized that mental health problems are not alleviated by providing treatment alone, since prevention is a primary necessary factor in promoting mental health and well-being. The logical target group for prevention of mental health-related problems is the child and the child's family. The Commission has suggested the crucial focus for prevention of mental disorders or disabilities must be on activities to eliminate the causes of the disorder (or, conversely, to promote mental health) and on very early detection and prompt treatment of once-recognized dysfunction.

There are several recently recognized and/or long-standing child and family problems which have focused public attention on the need for providing both preventive and restorative mental health services to children. These problems are cited in order to provide a context for considering the specific personnel training needs of mental health service providers. In addition, many children are especially vulnerable and "at-risk" as a result of many social situations and factors -- increased divorce rates, long-standing social inequity, poor schooling, increased availability of drugs, etc. The recognition of these social factors and their resulting impact on the developing child provides one basis for examining the specific personnel needs of this special population.

The provision of mental health services to children serves far-reaching purposes. The primary purpose is altruistic. It is to eliminate the immediately recognised suffering of children and adolescents. The second purpose is to provide a basis for preventing the development of later mental disorder, social dysfunction, or related problems. For these reasons it is especially important that the NIMH response to the Congress regarding a 5-year plan for increasing the supply of mental health service providers address the need for providers to serve this special population. The provision of mental health services to children and adolescents may also serve the important function of providing structured support and maintenance for the children of the rapidly-eroding nuclear family unit. The provision of mental health services to children may have direct and indirect consequences for the mental health of parents and siblings and/or may increase the capacity of the family to handle external social stress.

It has been estimated that there are some 5 to 6 thousand doctoral psychologists engaged in providing some mental health services to children. This represents about a quarter to a third of the total population of psychological mental health providers.

The National Register survey (Mills, Wellner, VandenBos, 1979) found that less than 1% of health service provider psychologists spend a majority of their time (over 75%) providing services to children. In addition, the report indicates that at least half of all licensed psychological practitioners provide little or no service to children. It should also be noted that, as with most health delivery services, the psychologists who serve children are maldistributed geographically and demographically. Most of these providers are located in large cities and generally serve a very narrow subset of the total population. The providers themselves are often representatives of a narrow subset of the population as well.

THERE ARE NO FIGURES AVAILABLE THAT ESTIMATE THE RATIO OF PSYCHOLOGISTS PER 100,000 CHILDREN IN THE POPULATION. HOWEVER, 1977 U.S. CENSUS DATA INDICATE A POPULATION OF 15,000,000 CHILDREN UNDER 5 YEARS OF AGE; 32,000,000 AGED 5 TO 13; AND 17,000,000 RANGING IN AGE FROM 14 TO 17. THESE AGE POPULATIONS REPRESENT 7, 15, AND 8 PERCENT OF THE TOTAL POPULATION, RESPECTIVELY. CHILDREN COMPRISE ROUGHLY 30% OF THE TOTAL POPULATION, RECEIVE ONLY 24% OF COMMUNITY MENTAL HEALTH CENTER SERVICES, AND LESS THAN 1% OF ALL PSYCHOLOGICAL SERVICE PROVIDERS ARE PRIMARILY DEVOTED TO SERVING THIS POPULATION.

THERE IS AN OBVIOUS SHORTAGE OF CLINICAL CHILD PSYCHOLOGISTS. WE ESTIMATE THAT THERE IS A CURRENT SHORTAGE OF 5,000 FULLY TRAINED CLINICAL CHILD PSYCHOLOGISTS, AND THAT ANOTHER 5,000 SUCH PSYCHOLOGISTS SHOULD BE TRAINED OVER THE NEXT DECADE.

Mental Health Needs of Ethnic Minority Populations and the Need to Eliminate the Shortage of Ethnic Minority Psychologists

According to the 1975 Special Census, the United States population included at the time of the census 38 million minority persons: 22 million Blacks, 12 million Hispanics, 3 million Asian/Pacific Americans, and 1 million American Indians/Alaskan Natives. Recent estimates suggest that the number may actually be higher. Thus ethnic minority peoples comprise between 18 and 20 percent of the total U.S. population.

The Task Panel on Special Populations of the President's Commission on Mental Health collected and presented a wealth of information indicative of demographic, economic, social and environmental factors which render ethnic minority populations particularly vulnerable to serious psychological and emotional distress. In addition to the pervasive psychological effects of racism and discrimination, there are other outstanding characteristics of ethnic minority populations which contribute to their plight. For example: (1) Whereas the median age for the general U.S. population is 28.6 years, the median age for Blacks is 21 years for males and 24 years for females. For Hispanics, the median age is 21 years; 14% of all Mexican Americans and Puerto Ricans are under 5 years old, as compared with 8% for the entire population. In the case of American Indians, 57% of the population is under 20 years of age; 25% of Indian children are removed from their homes for some sort of placement. (2) Whereas only 9% of Whites live in poverty, 31% of Blacks live in poverty. Hispanics are twice as likely to have large families (7 or more members) than the general population; 38% of these large Hispanic families live below the poverty level, with unemployment rates as high as 60 to 70 percent. (3) Black and Hispanic populations are most highly concentrated in urban areas, and particularly in the central cities of large metropolitan areas. For example, one out of two families of Hispanic origin lives in the central city of a metropolitan area, as compared with one out of four in the general population.

In addition to identifying ethnic minority populations as being at high risk with respect to emotional and psychological distress, the President's Commission determined that they have been "unserved" or "underserved" by the current mental health system:

> Appropriate services are not available to many of them, even though social, economic, and environmental factors render them particularly vulnerable to acute and prolonged psychological and emotional distress. often, services which are available are not in accord with their cultural and linguistic traditions. The number of Asian and Pacific Island American utilizing mental health services increases dramatically when services take into account their cultural traditions and patterns. Language barriers prevent many Hispanic Americans from seeking care, and when they do seek it, the absence of bilingual personnel can reduce the effectiveness of treatment. Government funded or operated programs often ignore existing cultural, social and community supports in the American Indian community.

A major factor in providing appropriate mental health care to ethnic minority populations is the availability of qualified ethnic minority service providers. As the Presidnet's Commission on Mental Health states: "A frequent and vigorous complaint of minority people who need care is that they often feel abused, intimidated, and harassed by non-minority personnel." Minorities sometimes feel more comfortable and secure when care is provided by practitioners who come from a similar background, although understanding and appreciation of minority cultural and value perspectives is also important.

A particular concern is the severe under-representation of ethnic minorities among providers of psychological services. Of all doctoral level health service providers in psychology, only 0.9% were Black, 0.7% were Asian American, 0.4% were Hispanic, and 0.1% were American Indian. Thus, collectively, ethnic minorities comprise only 2.1% of the doctoral level health service providers in psychology. The magnitude of under-representation may be placed in context by noting that, as was pointed out earlier, ethnic minorities constitute at least 18% of the U.S. population. In terms of actual numbers we can estimate that at the time of the survey (1976) a minimum of 3,600 additional ethnic minority doctoral level providers of psychological services were needed to achieve parity with minority representation in the general population.

IT IS DIFFICULT TO ESTIMATE WHAT THE LEVEL OF NEED WILL BE IN THE FUTURE. A MAJOR FACTOR OF UNCERTAINTY ARE THE WIDELY DIVERGENT PROJECTIONS FOR MINORITY POPULATIONS. FOR EXAMPLE, HISPANIC POPULATION ESTIMATES FOR 1985 RANGE FROM 13.4 MILLION TO 33 MILLION; FOR THE YEAR 2000 THE RANGE IS BETWEEN 17.5 AND 55.3 MILLION. THE BLACK POPULATION IS EXPECTED TO INCREASE BY 37.7% BY THE YEAR 2000. IN ANY EVENT, HOWEVER, IT IS COMMONLY ACCEPTED THAT,OVERALL, MINORITY POPULATIONS WILL INCREASE AT SIGNIFICANTLY HIGHER RATES THAN THE ANGLO-WHITE POPULATION, WHICH IS EXPECTED TO EXPAND BY ONLY 18.3% BETWEEN 1976 AND 2000. THESE TRENDS WILL EXACERBATE THE CURRENT UNDER-REPRESENTATION OF ETHNIC MINORITIES AMONG PROVIDERS OF PSYCHOLOGICAL SERVICES.

Although the representation level of 13% falls quite short of the 18% level of minority representation in the general population, these data show a six-fold increase over the 2.1% representation among 1976 health service providers in psychology. Although encouraging progress is being made, it should be emphasized that even when these minority students graduate and enter the professional field as service providers, the overall under-representation will still be on the order of several thousands, with specific shortage levels dependent upon the actual rate of expansion of ethnic minority populations.

Need for Clinical Neuropsychological Evaluations as an Example of Mental Health Personnel Shortages

It is also possible to look at a particular type of mental health service which is needed but not available in sufficient quantity, in addition to examining the overall service needs of specific populations. The need for neuropsychological evaluations is an example. The need for this service is extensive, and the populations in need of this service are highly varied.

Many individuals in the adult age range (e.g., 19-64) are in need of clinical neuropsychological evaluations. Such evaluations are frequently either unavailable or are inappropriately given by individuals lacking adequate training, or using inappropriate evaluation instruments. Adult patients who have suffered head or brain injury are most in need of a neuropsychological evaluation. Such injuries may be the result of focal brain damage, automobile accidents, tumors, embolisms, or cerebral vascular accidents. Such individuals are often otherwise healthy and have a highly positive prognosis for recovery and independent living, if an adequate neurospychological evaluation is conducted to make an accurate diagnosis and to aid in planning the rehabilitative process. It is with this particular age population that there is most frequently a need to make a determination of eligibility for special programs, for specialized care, or for disability insurance. In worker compensation cases, the most frequent site of injury is the back and the head. In those cases involving head injury and the ability to function in a work setting, neuropsychological evaluations are particularly valuable. It would be inappropriate and unfair to both the patient and the government to base such evaluations on inappropriate and inadequate testing. Neurological evaluation can frequently only assess very gross impairment. Clinical neuropsychological evaluations are able to assess more subtle impairment in cases of suspected brain injury.

Some initial evidence tentatively suggests that a subset of chronic schizophrenics are neurologically damaged. They demonstrate a brain atrophy that is measurable early through psychoneurological evaluations. In its advanced stage this atrophy can be physically confirmed through the use of CAT scans. One recent provocative report suggests that young acute schizophrenics can be differentiated into those manifesting this pattern of neuropsychological functioning found in chronic schizophrenics, and those not demonstrating this pattern (Golden, 1979).

It appears that the two groups may respond differently to traditional psychotherapeutic intervention, with the "chronic-appearing" (on neuropsychological test) patient being relatively unresponsive to traditional treatment. If these findings are supported by further research, it would provide a valuable diagnostic tool in the treatment of schizophrenia. It would allow us to know whom to treat with psychotherapy and whom to treat with other behavioral approaches. This is particularly important as we learn more about the damage that can result from prolonged used of psychoactive drugs.

Children and adolescents are also in need of neuropsychological services, in particular those who have experienced head injuries, tumors, brain damage related to genetic and blood disorders, and metabolic disorders such as kidney disease, liver disease, or lead poisoning. Children with cerebral palsy should also receive comprehensive neuropsychological evaluation. Children with this range of problems represent about 3% of all children, a subgroup which is among the most unserved (in many areas), underserved (in other areas), and in almost all cases inappropriately served (evaluated by poorly trained professionals using inappropriate instruments). P.L. 94-142, which mandates appropriate education for all handicapped children, defines learning disabilities in such a manner as to not recognize functional learning disabilities. Those children with emotional problems are to be excluded under this particular program. It is frequently estimated that about 12% of all children manifest some type of developmental disability but that only about a quarter of these are the result of actual brain impairment. Obviously, appropriate evaluation and diagnosis is critical for establishing a differential diagnosis in these cases.

The elderly are another population with a high incidence of problems warranting comprehensive neuropsychological evaluation. Neuropsychological evaluations are particularly useful in situations where there is a suspicion of a degenerative disease. In such cases, neuropsychological testing can provide a detailed picture of the individual's abilities and limitations, and can provide the baseline for comparing later evaluations so as to accurately assess the type and extent of loss of ability. The first evidence of Alzheimer's disease and Pick's disease, the two leading pre-senile dementia disorders, is usually evident on psychological testing, years before a definitive diagnosis is possible from other sources (Golden, 1978). It has been suggested that between 30 and 50 percent of stroke victims should be given a comprehensive neuropsychological evaluation because in about half of those cases the information would be useful in ascertaining what functions the individual retains and what functions it would be possible to retain. A similar situation exists for patients who have tumors or have had brain surgery. Clinical neuropsychological evaluations can be particularly useful both in establishing a baseline of functioning and in aiding in the planning of rehabilitative efforts. In those cases where a patient has suffered brain impairment which makes the capacity for independent living questionable, a detailed neuropsychological evaluation allows one to pinpoint which of these skills and abilities are adequate and which are not, so that a decision about living conditions can be made.

At the present time, it is estimated that there are only between 200 and 400 full-time clinical neuropsychologists in the country. The majority are located at medical training centers and VA hospitals, generally in large cities (most notably Washington, Boston, New York, Los Angeles, and San Francisco) and in Florida, a state with a large elderly population. These individuals tend to be jointly involved in training, research and service. The number of doctoral level psychologists who provide neuropsychological evaluations on a very limited basis is probably around 5,000. The majority of these individuals have traditional clinical psychological training, but had limited initial training in neuropsychological evaluation, and have supplemented that training with both practical and experience and continuing education. Generally speaking, the training has neither been extensive nor systematic.

There are probably not more than a dozen doctoral psychologists who have a two-year internship in clinical neuropsychology. The estimated number of clinical neuropsychologists who have had systematic professional training plus a full one-year internship, either predoctoral or post-doctoral, appears to be about 200. When the definition of a clinical neuropsychologist becomes an individual with specialized course work and a half year internship, the estimate appears to be about 500 individuals (Golden, 1979).

Golden and Kuperman (in press) surveyed all of the APA-approved clinical psychology training programs regarding offerings in clinical neuropsychology. They had a 64% response rate. Ninety-two percent of the programs responding reported offering graduate training in neuropsychology as part of basic clinical psychology training. Thirty-two programs offered specifically identified clinical neuropsychology courses and internships; 18 of these programs were sufficiently committed to such training as to encourage students specifically interested in neuropsychology to apply to their programs. This survey indicates a fairly high incidence of training availability in clinical neuropsychology. However, the majority of the more intensive programs (e.g., those which allow specialization) were established within the last four years, and have relatively small enrollments.

CLINICAL NEUROPSYCHOLOGY IS AN AREA WHICH NEEDS TO BE EXPANDED. THERE ARE MANY INDIVIDUALS IN NEED OF NEUROPSYCHOLOGICAL SERVICES WHO ARE CURRENTLY UNSERVED OR INAPPROPRIATELY SERVED. THERE IS A REASONABLE TRAINING BASE UPON WHICH EXPANSION OF TRAINING OPPORTUNITIES COULD BE BUILT. WE RECOMMEND A COMBINED TRAINING STRATEGY INVOLVING THE DEVELOPMENT OF A GREATER NUMBER OF PREDOCTORAL SPECIALIZED TRAINING PROGRAMS IN CLINICAL NEUROPSYCHOLOGY, AN INCREASED NUMBER OF YEAR-LONG POST-DOCTORALS IN CLINICAL NEUROPSYCHOLOGY, AND A SYSTEMATIC PART-TIME CONTINUING EDUCATION PROGRAM IN THE AREA. THE NEED FOR CLINICAL NEUROPSYCHOLOGISTS IS GREAT. ESTIMATES OF THE NUMBER OF ADDITIONAL CLINICAL NEUROPSYCHOLOGISTS NEEDED TODAY VARY GREATLY, FROM 1,500 TO 12,000. IT SEEMS REASONABLE TO SAY THAT 3,000 INDIVIDUALS SHOULD BE PRODUCED OVER THE NEXT DECADE.

Physical Health Problems and Mental Health Personnel Shortages

As national policy works towards integrating health and mental health service delivery, the mental health training system will need to provide expanded training relevant to the specific psychological problems of individuals with various physical health problems. In addition, once mental health professionals are functioning regularly in such settings, they will be pulled into developing behavioral interventions for physical health problems. In fact, this is already happening.

Behavioral approaches to physical health problems is the most rapidly expanding area of psychology. The APA Division of Health Care Psychology, Division 38, was formed only 21 months ago. Its initial membership numbered over 800 and at the present time more than 2,000 psychologists have joined the division. In addition, there is an Association of Behavioral Medicine Psychologists which has over 600 members, and an Association of Psychologists in Family Practice Medicine with over 400 members.

Although it is frequently assumed that psychologists are only mental health rather than health care practitioners, survey data by Dörken and Webb (1979) suggest a broader perspective. In their study, a detailed 57-item questionnaire was sent in 1977 to all of the licensed/certified psychologists in 10 states (a sample comprising about half of the licensed psychologists in the nation) and a 52% response rate was obtained. The Dörken and Webb survey was more detailed than earlier manpower surveys and addressed the actual practice of professional psychologists as they related to the scope of fee-for-service practice, hospital practice, insurance reimbursement experience, and information about the characteristics of the patients seen.

Dörken and Webb found that over two-thirds of all health care provider psychologists had some patients who were seen primarily due to psychological aspects of physical health problems. Considering the characteristics of the overall patient population, the data indicated that 18% of all the clients were seen primarily because of psychological aspects of organic illness, disease, dying, surgery, physical accidents, injury or dismemberment. The data indicated that health service provider psychologists quite frequently see clients for health reasons that go beyond traditional mental health notions, and that this is an expanding population of patients seen by psychologists. However, it was rare for a psychologist to specialize only in such problems.

Dörken and Webb provide other data which suggest that psychologists are active in the area of health care psychology (or behavioral medicine) and have already been well accepted, despite their relatively recent entry into this area. They found that 38% of the surveyed practitioners indicated that they "often" or "very often" got referrals from nonpsychiatric physicians. Further, 22% reported regularly making referrals to nonpsychiatric physicians. In addition, 19% of the health service providers indicated that community or government agencies were a prime referral source, and 17% indicated that they also referred patients to community/governmental agencies. These referral rates are comparable to those of psychiatrists (Avnet, 1972; Fink *et al.*, 1967).

As psychologists have become increasingly interactive with the physical health system, they have been well accepted and are becoming involved in a wider and wider scope of problems and activities. Their research orientation has been particularly valued, and it has proven useful in the analysis of physical health problems and the development of innovative behavioral treatments of them. We can expect further migration of mental health psychologists to the area of health care psychology or behavioral medicine, where the combined clinical/research training of psychologists has been particularly valuable. This "loss" should be allowed to continue, but the mental health training system should gear up to develop greater numbers of psychologist providers to offset this loss of mental health personnel.

Other Areas of Involvement and Mental Health Personnel Shortages

There are, of course, many additional areas which could be examined with regard to the need for additional mental health personnel, areas relating to special populations and relating to particular specialized services.

Primary prevention in mental health is one such area. Enough promise has been demonstrated in the limited efforts undertaken to date to justify substantial increases in research funding to stimulate growth and innovation. Sufficient expertise, research, and knowledge about prevention in mental health now exist to allow prevention efforts to be the immediate goal of some providers, particularly with high-risk populations. Primary prevention in mental health will become an increasingly active service area during the 80's. We must begin now to develop a sufficiently large pool of mental health professionals appropriately trained in this area, both to lead in the provision of prevention services and to train others.

But it is also critical to simultaneously provide sufficient research funding to insure that high-quality, effective prevention programs are developed.

The interface between psychology and the law is another growth area in need of support. Psychologists are involved in a broad range of activities in this area, from working with police officers regarding how to best handle family disturbances, to developing diversion programs for first offenders, to addressing the special mental health needs of incarcerated offenders. As the General Accounting Office has recently reported, the mental health needs of individuals in jails and prisons are grossly undermet. The unavailability of service is related to the lack of mental health personnel overall, to the lack of mental health personnel specially trained in dealing with these populations and the lack of appropriate funding mechanisms for such service.

There is a need to train greater numbers of psychologists in the mental health needs of rural American, especially the rural poor. Although the mental health needs of children and youth were discussed, the rapidly expanding area of pediatric psychology and the shortage of doctoral level school psychologists was only briefly noted. All of these represent areas in which service need is sufficient to warrant the training of additional personnel.

Finally, as mentioned several times throughout this report, attempts by the federal government to adequately meet the mental health needs of our nation will be less than successful if they are merely based on the training of health service providers. At the basis of service delivery is research, both basic and applied. A comprehensive training plan must include the training of researchers in the priority areas, in order to build the knowledge base upon which more effective services can be developed and delivered.

IN CONCLUSION

Overall, there is a vast, unmet need for mental health services. The entire nation is underserved, and some populations are extremely underserved. The magnitude of the service inadequacy is so enormous that merely improving the efficiency of the system of individual providers would not be sufficient to eliminate the service shortage. The current supply of mental health service providers is being utilized and, in the majority of cases, this utilization is appropriate. If the national policy were to shift providers from one type of service provision to another, we would merely redistribute the service shortage to new areas.

There are four basic problems related to the provision of adequate mental health services which must be simultaneously addressed: (1) numbers of relevantly trained professionals; (2) distribution of mental health professionals; (3) recognition and utilization of mental health professionals; and (4) development of mental health professionals.

(1) There are simply not enough trained mental health professionals to meet the current service shortages. Strategies such as the "primary care provider initiative in mental health" should have been viewed as a temporary aid, not a solution, for meeting a current service shortage, while an energetic, coordinated plan for training an increased number of mental health professionals was undertaken.

(2) It is clear that mental health professionals are not evenly distributed across the country. A similar situation exists for other professions and specialties. In addition to macro-geographic maldistribution, there is maldistribution by sub-area (e.g., rural, suburban, urban inner-city) and by type of treatment

facility (e.g., mental hospital, general hosptial, community health center, mental health center). There are many factors which contribute to maldistribution, including availability of cultural and educational opportunities, salary differentials, differing levels of familiarity with and acceptance of mental health services, and reimbursement policies. Nonetheless, NIMH does have the power, through its funding machanisms, to partially influence the distribution of providers. It should be used.

(3) It is clear that many individuals are not fully aware of the training and competence of all the core mental health professions. For example, the public appears to be well ahead of policymakers in terms of an up-to-date conceptualization of psychologists as health care providers, because it is the public that "consumes" 19,000,000 hours of psychological services annually (Gottfredson and Dyer, 1978). Policymakers, program planners, and program administrators seem to continue to operate on the basis of narrow and outmoded concepts about the training, competencies, and actual clinical skills and practices of psychologists, social workers, and nurses trained in mental health. They do not realize that all individuals with the same degree do not have the same training and are not necessarily competent to do the same clinical procedures. They need to be informed that not all psychiatrists are alike, not all psychologists are alike, etc., and that the key issue is the matching of specific relevant training and experience with the functions that are to be filled. NIMH should be taking the lead in providing realistic information on these matters, since it would lead directly to more appropriate utilization of mental health professionals and such positive experiences might well result in appropriate expansion of the utilization of mental health professionals in a range of settings.

(4) There is a need to produce mental health professionals with specialized knowledge and experience relevant to the particular needs of various unserved, underserved, and inappropriately served populations. This requires attention in training programs to information on social, economic, and cultural factors. It requires knowledge about the emotional and behavioral problems which accompany physical illness and disability, family and community disruption, and legal and educational difficulties. Knowledge of the goals, decision making processes, and operational procedures of formal and informal community service systems, as well as the current (and potential) roles of mental health professionals in them, is important in addressing unmet mental health service needs. There is also a critical need for courses which provide training in tailoring clinical skills and techniques to the unique needs of particular patient populations. NIMH should be encouraging and supporting the field in the development of such training. NIMH should be systematically monitoring current training, determining the relative frequency of specific types of course work and clinical experience, and assessing the relationship between the presence and absence of such training and job-taking behavior and job performance. NIMH does have power. It should use its influence, via funding, to shape and restructure core curricula and specialty training in appropriate and effective directions.

The importance of systematic core training in the mental health professions cannot be underestimated. The best base upon which to provide specialized training or retraining is systematic core or basic professional training. Federal funds for targeted or specialized training will be most effectively utilized and efficient in accomplishing their intended goals only if they build on a solid base of professional training. If only specialized and technical clinical training is funded, however, the professionals developed possess only narrow expertise and skills, which may become outmoded or inappropriate in other settings or at a later time. We know that most mental health professionals work in several specialty areas over the course of their career. Narrow initial training would require costly and separate retraining. It is imperative that the implementation of targeted training not produce second-class professionals to serve those individuals and populations who are currently designated as unserved or underserved. Just as it is basic to science, breadth and diversity of training (both by discipline and specialty) is critical to the mental health service area. The best way to encourage innovation is through a broad base of training. If only one model of training for one service is supported, innovation in the mental health field will be seriously hampered.

It is clear that as we consider specialized training to meet specialized needs, we need to incorporate, as part of the overall policy, the explicit recognition that a certain base of broad professional training and experience is necessary (and should be supported), as well as more in-depth concentrated and specialized training in particular problems, populations, and techniques. Flexibility is needed in our training system. Much of the strength of our current system of training lies in the balance and interaction between service and research, theoretical orientations (intrapsychic, behavioral, psychosocial, biological) and humanitarian commitment and rigorous evaluation.

Coalition of Independent Health Professions

Office of the Chairman

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March 26, 1980

Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and Scientific Research
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

As Chairman of the Coalition of Independent Health Professions (CIHP), I am pleased to have this opportunity to submit to you for the record of the hearings of the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources on March 12, 1980, the following statements of concerns and recommendations with respect to the present proposed legislation to amend and extend the current health and manpower training authorities contained in Title VII of the Public Health Service Act, as amended.

CIHP was formed in the spring of 1970 as a vehicle for shared leadership in health care matters and provides its member organizations a forum for receiving and sharing information on improving quality health care, health planning, the delivery of health care services and assuring the citizens of the United States of adequate numbers of qualified personnel. Membership in the Coalition is accorded to organizations which are broadly representative of discipline-centered professions with significant involvement in the delivery of health services and, collectively, CIHP represents over a quarter million (250,000) non-physician health care professionals. Membership in CIHP is composed of the following organizations:

American Association for Clinical Chemistry
American Association of Bioanalysts
American Association of Pastoral Counselors
American Dietetic Association
American Occupational Therapy Association
American Optometric Association

MEMBER ORGANIZATIONS

American Association of Bioanalysts
American Association of Pastoral Counselors
American Dietetic Association
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Society for Medical Technology
American Speech Language Hearing Association
National Association of Social Workers
National Rehabilitation Counseling Association

American Physical Therapy Association
American Society for Medical Technology
American Speech-Language-Hearing Association
National Association of Social Workers
National Rehabilitation Counseling Association

Insofar as allied health professionals comprise approximately three-fifths of the total health work force which now numbers over 5 million, and insofar as CIHP represents a significant portion of these allied health professionals, we are intimately concerned with the management of and the direction to be taken by America's health care delivery system.

Definition of Allied Health

CIHP is particularly concerned with the current inadequate and inappropriate definition of "Allied Health Personnel" as set forth in Section 751 (relating to the National Health Service Corps) and continued in Section 795 (1) of the current statute. CIHP perceives this current definition as both inappropriate and derogatory, and this to the extent that at least one member of CIHP has for some time strongly dissuaded its members from seeking federal training assistance under the Part G Allied Health Authorities of Title VII.

This current system which, in effect, requires health care professionals to derogate their professional status as a condition for the award of federal assistance not only is discriminatory but also does not further the legislative intent on which the Part G authorities were based, nor does it contribute to the solution of the needs and shortages these authorities were meant to address.

It is, therefore, with a great deal of relief that we note current legislative awareness of this problem. For example, Senator Kennedy's bill (S.2375) would eliminate this unfortunate distinction in part by referring to all health care practitioners affected by Title VII as "personnel." Senator Schweiker's proposal, S.2144 in Section 700(a)(7), does away with the current listing of examples of allied health personnel which, in the first instance, is not truly representative of the spectrum of non-physician health care providers, nor, in the second instance, is a definition even necessary in light of the fact that none is offered for medical, dental, or podiatric personnel.

The preferable standard to be applied is that which is currently applied to these latter professions, i.e., just as the definition of the schools which train these medical, dental, or podiatric personnel so, too, should this be the model standard by which allied health personnel are determined. Consequently, we suggest that the Subcommittee:

> Delete section 795(1) of the current statute and amend the current section 795(2) by substituting, in lieu thereof, subsections (A), (B), and (C) of section 700(a) of proposed S.2144. Subsection (D) of existing section 795(2) should be retained.

Data Studies

CIHP strongly feels that an additional emphasis should be placed on data studies relevant to proper utilization of non-physician health care providers. A recent study entitled A Report on Allied Health Personnel prepared by the Bureau of Health Manpower of the Health Resources Administration pursuant to section 702(d) of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), as amended, has, among its many findings stated:

> "There are insufficient data about allied health personnel at the local, state, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service costs, and work force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, federal support appears to be a decisive factor."

Another report has been completed as the product of a two-year study conducted by the National Commission on Allied Health Education. This report, entitled The Future of Allied Health: Alliances for the 1980's, arrives at much the same conclusion as the above cited Report:

> "The Federal government should support the systematic and continuous collection and dissemination of data on the numbers and distributions of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which continue to offer formal post-secondary education programs."

Currently, the Federal government supports Allied Health related data collection relating only to those Allied Health schools defined in existing section 795(2), those awarding the associate, baccalaureate or higher degree, and does not take into account the increasing number of other educational institutions which award certificates as opposed to degrees. Consequently, and to accomplish these aims, we urge the Subcommittee to:

> amend the existing data collection language of section 708;

or to:

> add a new section to Part G to accommodate the need for the collection of Allied Health (including post-secondary nonprofit and proprietary institutions which grant practice "certificates" in Allied Health disciplines, including data relating to production, recruitment, reimbursement, utilization, service costs, work force quality, educational standards and methods, and opportunities for minorities.

Access to Grants

The Report of the Bureau of Health Manpower concludes that:

- While some of the previous shortages of allied health personnel have been alleviated or eliminated, there remain significant shortages in the areas of respiratory therapy, speech pathology, and audiology, and that, to a lesser degree, shortages remain of formally trained dental assistants, in dietetics, radiation therapy, occupational therapy, and physical therapy;
- The duties and responsibilities of allied health personnel have markedly increased in recent years;
- As a cost-saving strategy, increased use of allied health personnel is thought to have considerable potential, especially in HMO's and long-term care; and
- The quality of training has increased significantly in recent years, but further improvements are required.

Consider also the statistics from the Occupational Projections and Training Data, Bureau of Labor Statistics, with an expected publication date of May 1980. Reproduced here for the Subcommittee's convenience are the statistics for a number of the allied health professions:

Occupation	Estimated employment 1978	Projected employment 1990	Change
Optometrists	21,000	26,000	25.2
Medical Laboratory workers	210,000	265,000	26.2
Occupational therapists	15,000	30,000	100.0
Occupational therapy assistants	10,000	15,000	50.0
Physical therapists	30,000	45,000	50.0
Physical therapy assistants and aides	12,500	15,000	20.0
Dietitians	35,000	50,000	42.9
Rehabilitation counselors	19,000	NA*	NA
Social workers	385,000	475,000	24.2
Speech pathologists and audiologists	32,000	60,000	87.5

*NA = data not available

The Report of the National Commission on Allied Health Education asserts that non-physician health personnel, comprising close to two-thirds of the health work force, are essential to the national well-being, and that it should be the responsibility of the Federal government to ensure that national-level priorities are met.

The Commission found that during fiscal years 1965-1976, a total of $4.2 billion was appropriated by the Federal government for health manpower education, but that, despite the importance of non-physician health personnel, only $183 million, slightly over 4 percent, was allocated to allied health education.

In light of the conclusions revealed in the Report of the Bureau of Health Manpower and the statistics brought to light in the study soon to be published by the Bureau of Labor Statistics, this funding discrepancy evidenced in the disproportionately small allocation to allied health education is clearly unacceptable.

CIHP therefore urges the Subcommittee to reconsider this pattern of allocation, and suggests the following legislative action:

> the purposes of section 798 should be retained in the Subcommittee's final legislative proposal. In addition, the following project-support emphases should be added to those already enumerated: role delineations and related interdisciplinary curriculum modules; meeting new health-service needs without creating new specialities; the development of mechanisms for interdisciplinary articulation; the use of non-physician health personnel in containing health-care costs; the health needs of unserved and underserved areas vis-a-vis non-physician health personnel; curriculum offerings in health promotion, disease prevention, geriatrics, and health planning; increased development of faculty; outcome validation studies; minority representation; and the effect of federal reimbursement policies on maximum utilization. The authorization levels for existing section 796 should be $30 million for fiscal 1981, $32 million for fiscal 1982, $34 million for fiscal 1983, and $36 million for fiscal 1984.

Existing section 797 authorizes $5.5 million for the current fiscal year for institutes generally designed to accommodate the "advanced" learning needs of Allied Health practitioners who, principally as a result of the rapid expansion of the Allied Health fields and increases in the numbers and varieties of Allied Health opportunities and initiatives, find themselves in new educational, supervisory, or administrative settings. CIHP urges that this emphasis should be continued and, therefore, recommends that the final Subcommittee proposal should:

> include existing section 797 through fiscal year 1984 at annual authorization levels which are at least equal to that of the current fiscal year.

A significant aspect of the Congress' rationale for initiating, in 1966, federal-support programs in Allied Health education was its belief that the Allied Health professions could help the health-care delivery system's need to increase services to unserved and underserved areas of the country. The non-physician professions have since proven their effectiveness in these areas --

allied health services are diverse; so are the critical health-care needs in unserved rural and urban areas. Yet the allied health professions have been virtually ignored by National Health Services Corps planners.

In 1979, for example, only 28 of 2,379 NHSC scholarships went to allied health students (all 28 were awarded to master's level students in public health nutrition programs). It is difficult to believe that podiatry services, for example, are any more crucial to the health-care needs of underserved populations than the services of audiologists or physical therapists or rehabilitation counselors (106 podiatry students benefited from NHSC assistance in 1979). Consequently, CIHP urges the Subcommittee to:

> include students in the allied health professions among the health professions students qualified for NHSC education assistance and service.

CIHP wholeheartedly applauds the proposals by Senator Kennedy and Senator Schweiker which would focus special federal support on specified health-care priority needs. We agree that:

> clinical training, health policy and health-care economics, continuing education, educational costs, curriculum development, and the role of women in health-care education and service are all appropriate areas for special federal funding emphasis. Allied Health training programs should be specified as appropriate recipients of such special funding.

Moreover, with regard to the above documented evidence of national shortages in the manpower forces of the Allied Health professions, CIHP specifically urges the Subcommittee to report an amendment to existing section 796 to:

> enable the Bureau of Health Manpower to provide special incentive support to Allied Health education programs which train students in disciplines identified as "significant national shortage" areas, notably audiology, speech pathology, respiratory therapy, dietetics, dietetic technology, physical therapy, occupational therapy, radiation therapy, and dental assisting.

CIHP sincerely appreciates this opportunity to present its concerns for the record of these hearings. We are also pleased to offer you or your Subcommittee staff the assistance of our personnel should any additional information or assistance be required.

Sincerely,

Morgan Downey

Morgan Downey
Chairman

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INSTITUTE OF FOOD TECHNOLOGISTS
SOCIETY FOR NUTRITION EDUCATION

Liaison Organizations

AMERICAN ACADEMY OF PEDIATRICS
  COMMITTEE ON NUTRITION
AMERICAN COLLEGE OF NUTRITION
AMERICAN HOME ECONOMICS ASSOCIATION
AMERICAN SOCIETY FOR PARENTERAL
  AND ENTERAL NUTRITION
NATIONAL ACADEMY OF SCIENCES
  FOOD AND NUTRITION BOARD

Kristen McNutt, Ph D
Executive Officer

POSITIONS AND STATEMENTS OF THE NATIONAL NUTRITION CONSORTIUM BOARD

The National Nutrition Consortium is a non-profit organization comprising the major professional societies in food, nutrition and dietetics. The cumulative membership of these societies totals approximately 80,000 scientists, physicians, educators and dietetians who have education, expertise and experience in nutrition.

Policy and programs of the Consortium are determined by a board composed of three voting delegates from each sponsor society and one non-voting delegate from each liaison society. Board members serve for a three year term. New members to fill expiring terms are nominated by their member organizations and elected by the current Board at the meeting prior to July 1 of each year.

Positions are taken and statements made by the Board of the National Nutrition Consortium. Official statements must be approved by two voting members from each of the sponsor societies. Liaison organizations do not vote on Board positions. Board statements and positions are not approved by the governing councils of the member organizations but they are communicated via the Board members to all member organizations. Board statements on a particular topic take into consideration existing positions of member organizations when such are available.

As a Consortium of organizations, there are no individual members of the National Nutrition Consortium. The Board of the Consortium meets regularly to review staff and committee activities, to initiate new programs and to determine Consortium policy.

The President and Executive Officer of the Consortium are authorized and encouraged to communicate with the public and policy makers on matters related to foods and nutrition.

Sponsor Organizations
American Dietetic Association
American Institute of Nutrition
American Society for Clinical Nutrition
Institute of Food Technologists
Society for Nutrition Education

January 1980

nutrition or other mentioned areas.

Sincerely,
Robert E. Olson ag
Robert E. Olson, M.D.
President
National Nutriton Consortium

REO/nl

Center is sufficient for adequate representation. One "administrator" representative and one "faculty" representative would be a more definitive designation.

Section 708 (a)-"Health Personnel Data"

We support the value of routine data collection and analysis related to "Health Personnel" status in the United States. "Health Personnel" needs are not static, but will vary with changes in the Health Delivery systems, new medical breakthroughs, new roles of "Health Personnel" and other diversified forces. It may be important to define "essential" information which should be collected annually rather than every two years.

Section 107 (a), Section 748 (b) "Traineeship Loans"

We would recommend inclusion of the words "public health nutrition" to provide added clarity.

Section 745-"Loan Program"

"School of Public Health" should be amended to read "School or Program in Public Health."

We would further point out that S.2375 makes no reference to Food Scientists who carry responsibility for provision of a food supply which must meet the needs of all U.S. citizens and aid to the world.

Section 820-"Special Project Grants and Contracts" (Nursing)

We suggest consideration be given to the inclusion of nutrition education projects for providing nursing personnel with necessary skills to cope with today's diversified patient care needs.

Comments on the Schweiker Bill - S.2144

Section 103-The title, "Training of Health Professions and Allied Health Personnel" would be better understood by using the term "Health Professionals". We see no objection to using Health Personnel, but we do object to separating Health Professionals from Allied Health Personnel.

Section 700 (8)-, page 10 - "Training Centers"

Because there are accredited programs in public health nutrition and dietetics which are not located in Schools of Allied Health or Public Health, the word "programs" should be included.

Part C - "Special Projects"

Existing schools and departments who already have increased the nutritional content of existing courses are in effect penalized by this "bonus" offering. Special safeguards should be instituted to assure that teaching personnel have the qualifications for teaching

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Kristen McNutt, Ph.D
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Dr. Myrtle L. Brown (FNB)
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Dr. Ivy M. Celender (AHEA)
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Dr. Marjorie Devine (SNE)
Cornell University

Dr. Donald A. Elliott (ACN)
Smithsonian Science Information Exchange

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Dr. Harry L. Greene (ASCN)
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Utah State University

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Dr. James Kirk (IFT)
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Dr. Bernard S. Schweigert (IFT)
University of California, Davis

Dr. Esther Winterfeldt, R.D. (ADA)
Oklahoma State University

Dr. Calvin W. Woodruff (AAP)
University of Missouri

Dr. Kathleen Zolber, R.D. (ADA)
Loma Linda University

May 2, 1980

The Honorable Senator
Edward Kennedy
Chairman, Senate Health
Subcommittee
Room 308 C, Senate Ct. Bldg.
Wash., D.C. 20510

The Honorable Senator
Richard S. Schweiker
Senate Health Subcommittee
2253 Russell Senate Office
Building
Washington, D.C. 20510

Dear Senators Kennedy and Schweiker:

The National Nutrition Consortium is a non-profit organization comprising the major professional and scientific societies in food, nutrition and dietetics. The cumulative membership of these societies totals approximately 80,000 scientists, physicians, educators and dietitians who have expertise and experience in nutrition.

The National Nutrition Consortium is currently expanding its efforts to provide constructive comments and criticisms regarding proposed Senate bills on nutrition policies. A Health Manpower Issue Committee, consisting of individuals in the sponsor societies whose experience and training qualify them to comment on issues pertaining to Health Manpower has been formed.

This committee compiled the following comments on S.2375 and S.2144 and the Consortium Board endorsed the comments. I am enclosing a statement describing the National Nutrition Consortium policy on official Board statements.

We appreciate the opportunity to respond to S.2375 and S.2144 and your willingness to review our following comments:

Comments on the Kennedy Bill - S.2375

Section 1 - The title "Health Professions Training and Distribution Act of 1980", is satisfactory.

Section 702 (a)-"National Advisory Council on Health Personnel".

We agree with the change in number from "twenty" to "twenty-two" members but question if one representative from an Allied Health Training

National Nutrition Consortium, Inc.

Suite 1 • 1635 P Street, N.W., Washington, D.C. 20036 • (202) 234-7760

[illegible]

AMERICAN DIETETIC ASSOCIATION
AMERICAN INSTITUTE OF NUTRITION
AMERICAN SOCIETY FOR CLINICAL NUTRITION
INSTITUTE OF FOOD TECHNOLOGISTS
SOCIETY FOR NUTRITION EDUCATION

Liaison Organizations

AMERICAN ACADEMY OF PEDIATRICS
COMMITTEE ON NUTRITION
AMERICAN COLLEGE OF NUTRITION
AMERICAN HOME ECONOMICS ASSOCIATION
AMERICAN SOCIETY FOR PARENTERAL
AND ENTERAL NUTRITION
NATIONAL ACADEMY OF SCIENCES
FOOD AND NUTRITION BOARD

March 17, 1980

Senator Edward M. Kennedy
Chairman, Senate Health
Sub-Committee
Room 308 C, Senate Court Bldg.
Washington, D.C. 20510

Dear Senator Kennedy:

The National Nutrition Consortium endorses the statement of the American Society of Allied Health Professions on the legislation to amend and extend current manpower and training authorities contained in Title VII of the Public Health Service Act(as amended). This statement was presented by Lee Holder, Ph.D., President of the American Society of Allied Health Professions, on March 12, 1980.

The National Nutrition Consortium interests in Health Manpower, while not limited to Allied Health Manpower, does encompass Allied Health disciplines related to nutrition and dietetics. We represent 80,000 of the nutrition and dietetic community. As such, we are most concerned about the manpower needs to maintain high quality nutritional care of all citizens, assurance of quality education and continuing education of Allied Health manpower is of utmost importance.

The National Nutrition Consortium wishes to note that there are programs in Public Health Nutrition and Dietetics not located in Schools of Public Health or Allied Health. We would therefore request that Senate bill 2144 be amended in sections 746 and 747 to permit a continuation of the provisions of the existing law regarding the eligibility of institutions to compete for project grants and grants for traineeships in nutrition and dietetics.

Sincerely yours,

Joan Sharp
eb

Joan Sharp, R.D.
Chairman, Health Manpower Committee
National Nutrition Consortium

JS:nl

AMERICAN FOUNDATION FOR THE BLIND, INC.

1660 L STREET, N.W.
WASHINGTON, D.C. 20036
TEL. 202 467-[illegible]

STATEMENT OF ALAN M. DINSMORE, SPECIALIST IN GOVERNMENTAL RELATIONS, AMERICAN FOUNDATION FOR THE BLIND, THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH, COMMITTEE ON LABOR AND HUMAN RESOURCES, U. S. SENATE, ON PENDING HEALTH MANPOWER LEGISLATION, MARCH 21, 1980

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to present the views of three national organizations concerning legislation to revise and extend Title VII - Health Research and Teaching Facilities and Training of Professional Health Personnel - of the Public Health Service Act.

The three organizations I am representing are the American Association of Workers for the Blind, the national membership organization of professional workers serving blind persons; the American Foundation for the Blind, the national voluntary research and consultant agency in services to blind persons of all ages; and the Blinded Veterans Association, the Congressionally chartered membership organization of the Nation's warblinded.

All three of these organizations are interested in the approaches taken by S. 2375, S. 2144, and S. 2378 regarding incentives for interdisciplinary training, special projects, and allied health authority training as they pertain to rehabilitation. We are particularly interested in the training under allied health authority of three types of allied health professionals to meet the unique needs of blind and severely visually impaired persons. These are: (1) the low-vision technician, who trains a severely visually impaired individual in the use of low vision aids (various kinds of lens systems) to enable him to make maximum use of residual vision; (2) the orientation and mobility specialist, who trains a blind individual in techniques which enable him to walk safely and remain oriented in a variety of settings without the use of sight; and (3) the rehabilitation teacher, who trains a blind person a variety of personal management skills, exclusive of mobility skills, to enable him to achieve maximum functional independence without sight.

Comprehensive low vision service has as its objective the attainment of optimum visual efficiency in legally blind and severely visually impaired individuals. Effective low vision service requires vision evaluation, optical aid prescription, and the training of the patient on a team basis. These procedures require a detailed opthamological examination, an optometric low vision examination, and specialized training of the patient by a low vision technician in the use of the prescribed low vision aid.

To our way of thinking, shortages in orientation and mobility, rehabilitation teaching, and low vision technician personnel becomes critical when viewed in the context of the following factors:

- Severe vision loss, including blindness, now affects more persons over 65 than all other age groups combined. And AFB projections based on National Center for Health Statistics rates forecast that, in the 20 years remaining before the year 2000, blindness and severe vision impairment among the 65 plus age group will increase by one-third. Program planning and service delivery by low vision professionals to this population becomes even more an issue for the extension of authorities under Title VII because evidence provided to the U. S. Senate's Special Committee on Aging shows that 38 percent of the Nation's elderly live in rural, medically underserved areas.

- P.L. 94-142, "The Education for All Handicapped Children" Act mandates "free appropriate public education...to meet the unique needs of a handicapped child, at no cost to parents or guardians." While the Act specifies the provision of "related services" it does not specify who pays the bill and provides no assistance for training health and rehabilitation professionals who, particularly because of the "mainstreaming" features of the law, must now serve a more widely dispersed population.

Education of the Handicapped Act, as amended by Public Law 94-142:

-"(17) the term 'related services' means transportation, and such developmental corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children."

- The Rehabilitation Act of 1973 as amended by The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (P. L. 95-602) provides new authority supported by appropriations for independent living skills and special programs for the blind who, because of the severity of disability, may not qualify for more conventional vocational rehabilitation programs.

We are very much concerned that these federal mandates, while providing the basis for innovative and very much needed programs, are based on the assumption that present training authorities for orientation and mobility specialists, rehabilitation teachers, and low-vision technicians are geared to providing sufficient numbers of new professionals.

Not only are they not geared by level of appropriations support, present authority for training is not suitable for providing for assisting the new populations who must be served under federal law. For example, several colleges and universities are providing training for orientation and mobility specialists with financial assistance from the Rehabilitation Services Administration and the Office of Education. The principle purpose of these two authorities is to train blind and severely visually impaired children and adults with vocational rehabilitation potential. Yet, the vast majority of newly blind individuals lose their sight after the optimum age for vocational rehabilitation.

A further point, unlike the approaches provided by bills under consideration by your Subcommittee, present training authorities for professionals in service to the blind provide little or no assistance in either interdisciplinary training or upgrading of basic skills..

Training in blindness rehabilitation, because of these limitations, does not prepare workers adequately for the number and types of multi impaired clients they may encounter. And, although individual programs at their own initiative have developed new techniques, no wide-based training authority exists to implement these programs. As a result, much of the rehabilitation expertise designed to teach individuals how to compensate for loss of sight is undermined when potentially compensating physical, sensory, or mental capabilities are also impaired.

Some measure of the necessity for dealing with the problem can be derived from a 1977 Health Interview Survey prepared by the National Center for Health Statistics which shows that, even excluding many chronic conditions, a majority of severely visually impaired persons have one or more additional impairments. For example, the incidence of multiple impairment including severe vision loss rises to 66 percent of the 65 plus population.

Traditional service patterns for those populations have had a heavy institutional/residential emphasis. Recent developments, primarily deinstitutionalization for the mentally disabled with attendant emphasis on community living in the least restrictive housing situation and emerging programs emphasizing community living alternatives versus nursing home care, are changing these patterns. For example, in New York state, an increasing number of multi-handicapped blind persons from such institutions as Willowbrook State School, the Suffolk County Developmental Center, Pilgrim State Hospital and others are being referred for rehabilitation services to community-based agencies for training in skills like orientation and mobility and independent living skills taught by rehabilitation teachers for the blind.

The present Training Authorities provide little or no support for development of advanced skills to serve the multi-handicapped child. Further, local and state funding is simply not designed to support the training of students whose services are typically needed in areas outside of the state or local area. In this case, employment of these Blind Rehabilitation Specialists follows the general trend of allied health personnel-wide geographic dispersement after training.

By the end of 1980, there will be approximately 1,000 rehabilitation teachers working within the field of blindness. Presently five (5) universities specialize in training rehabilitation teachers for the field of blindness. Current sources of funding have remained level while predictable increases in service needs indicate the need to develop at least five (5) more university level training programs. The rehabilitation teacher will be particularly important in teaching personal management skills exclusive of mobility to elderly blind persons in their own homes and deinstitutionalized multi-handicapped blind persons in new community living arrangements.

There are now about 1,200 orientation and mobility specialists employed by public and private non-profit rehabilitation facilities, public and private agencies for the blind, residential schools for the blind, and various public school programs. Yet, a safe estimate is that not much more than 25 percent of the visually handicapped who could profit from orientation and mobility training have received such training from a certified instructor. Twelve universities offer programs in this specialty and each year there are approximately 100 graduates from these programs who enter the field. Establishment of continuing education program authority for graduates of these programs is needed if these health professionals are to offer the new services required by the multi-handicapped blind and a large numbers of unserved elderly blind.

Therefore, we are pleased to note the authority under Title VII provided proposed by S. 2375 for retraining and establishing continuing education for practicing allied health professions and also the new Section 795 of the Public Health Service Act proposed by S. 2375 to provide for "Special Projects in Nutrition, Geriatrics, Rehabilitation, and the Containment of Health Care Costs." These approached would be of mugh assistance to allied health professionals.

To our way of thinking, S. 2144 would also provide vital assistance, particularly in Section 746 to provide for "Projects and Advanced Traineeships for Allied Health Personnel."

Since Title VII of the Public Health Service Act grants the Secretary of Health, Education, and Welfare broad authority in designating the types of allied health professionals who can be trained under its provisions, we would urge the Committee to include in its report accompanying to extend health manpower programs specific intent language directing the Secretary to initiate programs at institutions of higher learning for training of low vision technicians, mobility specialist for the blind and rehabilitation teachers of the blind.

THE CITY OF NEW YORK
THE PRESIDENT OF THE COUNCIL
CITY HALL
NEW YORK, N. Y. 10007

CAROL BELLAMY
PRESIDENT

(212) [illegible]

March 28, 1980

Honorable Edward M. Kennedy
United States Senate
Chairman, Labor and Human Resources
Subcommittee on Health and Science
Research
4230 Dirksen Senate Office Building
Washington, D.C.

Dear Senator Kennedy:

Attached is my testimony on the issue of Foreign Medical Graduates (FMG's) and the impact changes in federal policy and statutes is having on New York City. I have also included a copy of a report prepared by my office which quantifies this impact.

I request that both my testimony and report be included in the record of your subcommittee hearings. If I can be of any further assistance please feel free to call me.

Sincerely,

Carol Bellamy

CB:oh

Attachments

Mr. Chairman, Members of the Subcommittee:

Thank you for giving me this opportunity to submit testimony on foreign medical graduates (FMG's) in New York City teaching hospitals.

The National Health Professions Educational Assistance Act of 1976 tightened the educational standards and visa qualifications necessary for foreign medical graduates desiring to enter the United States for post-graduate training. It also imposed a two-year time limit on such training programs, with an optional third year if requested by the FMG's home country.

The potential adverse consequences of this change in policy did not go unnoticed by Congress. The 1976 legislators provided a phase-in period which waives the more stringent educational requirements if a particular training program can demonstrate that a "substantial disruption in medical services" would otherwise occur. This phase-in period runs out in December, 1980, at which time the more restrictive immigration requirements will have full force and effect.

New York City will face a critical doctor shortage in the coming months unless present law is revised to:

- Postpone implementation of these restrictions until December 31, 1985;
- Allow FMG's entering the country under new restrictions to stay long enough to complete their training program (usually four to five years);
- Permit National Health Service Corps doctors the

(More)

option of using postgraduate training in some instances, as fulfillment of their Service obligation. Under the current law, Corps doctors receive assistance in exchange for payback service in medically under-served areas only after training is completed. Present law also precludes any Corps service in municipal hospitals.

Foreign medical graduates (FMG's) now account for approximately 40 percent of all interns and residents in all New York City hospitals. Loss of these doctors will jeopardize City health services and affect those who have the greatest need - the poor who rely on doctors as their family physicians.

Appended to this testimony is a report prepared by my office which details the adverse impact of the 1976 immigration amendments on New York City hospitals, particularly municipal institutions, and offers recommendations to minimize this impact.

As the report documents:

- The loss of FMG's will be most severely felt in the industrialized sections of the Northeast and North-Central states. New York City is, and will continue to be, particularly hard hit. The City - with its large concentration of teaching hospitals - now trains one of every twelve physicians nationwide. As part of their training interns and residents deliver essential medical services to many New Yorkers.

(More)

- Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056 -- 38 percent -- were FMG's. These foreign doctors amount to more than 50 percent of the housestaff in twenty-three hospitals, and in twelve of these institutions, the proportion of FMG's is more than 75 percent. For instance, at Harlem Hospital, foreign medical graduates hold 100 percent of all housestaff positions in pathology and anesthesiology, 86 percent in pediatrics and 78 percent in psychiatry. And in Brooklyn, where FMG's make up 93 percent of all pediatricians at the Health and Hospitals Corporation facilities, the borough could be left without children's services in municipal hospitals should the restrictive immigration requirements go into full effect. Tables I-VII of my report further detail the impact of reduced foreign doctors on hospital-based services, particularly in primary care.

I agree with the federal policy on FMG's. I too am concerned about the "brain drain" from physician-poor countries to the United States. From 1966 to 1977, a 6 percent annual increase in the number of American medical graduates has helped to alleviate the physician shortage of the early sixties which justified liberal immigration policy.

(More)

Until recently, the hospital community in New York City, including the Health and Hospital Corporation, had not used the time already allowed by the federal government to seek replacements for FMG's. Therefore, a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of qualified FMG's must be a part of any interim stop-gap measures. The Corporation has already made a commitment to develop and implement such a plan.

However, we need time and federal assistance to avoid real reductions in physician services. In order to provide us with that time and assistance I have recommended the following legislation:

1) The phase-in period of the law must be extended from December 31, 1980 to December 31, 1985, allowing the federal government to continue granting waivers to avoid a "substantial disruption of health services." Of the 145 waivers granted nationally, between 1978 - 1980, 107 were for New York City hospitals. As of February, 1980, 95 of the 96 national waivers pending came from New York City.

2) Coordinate the length of a foreign doctor's stay in the United States with the length of the training program. Alien physicians who come to the United States for graduate medical education, and who

(More)

OTHERWISE QUALIFY FOR ENTRY, SHOULD BE ALLOWED TO REMAIN FOR A PERIOD EQUAL TO THE LENGTH OF THEIR PROGRAM. THIS WOULD ENABLE FMG'S TO RETURN HOME WITH APPROPRIATE SKILLS. ALSO, MEDICAL CARE WOULD NOT BE COMPROMISED BY SHORTAGES OF UPPER-LEVEL RESIDENT PHYSICIANS, CREATED BY THE FORCED DEPARTURE OF FMG'S AFTER TWO YEARS.

3) INCLUDE MUNICIPAL AND VOLUNTARY HOSPITAL TRAINING PROGRAMS IN NATIONAL HEALTH CORPS SERVICE COMMITMENTS. THE LAW SHOULD BE AMENDED TO ALLOW PARTICIPATION IN DESIGNATED TRAINING PROGRAMS IN VOLUNTARY AND MUNICIPAL HOSPITALS TO FULFILL THE PHYSICIAN'S SERVICE OBLIGATION. PROGRAMS SHOULD BE DESIGNATED ONLY,

- IF THEY INVOLVE PRIMARY CARE SPECIALTIES IN MEDICALLY UNDERSERVED AREAS;
- ARE IN DEPARTMENTS CURRENTLY DEPENDENT ON FMG'S FOR THE PROVISION OF CARE;

IN ENACTING THIS LEGISLATION, WE MUST NOT LOSE SIGHT OF THE LARGER ISSUE OF MALDISTRIBUTION-BY SPECIALTY AND GEOGRAPHY OF PHYSICIANS TRAINED HERE IN THE UNITED STATES.

REDISTRIBUTING MEDICAL PERSONNEL, SO THAT ALL SPECIALTIES AND REGIONS ARE SUFFICIENTLY COVERED AND ACCESS TO HEALTH CARE IS ASSURED FOR THE POOR AND WORKING CLASS, DEPENDS ON

(MORE)

REORDERING THE PRIORITIES OF AMERICAN MEDICAL EDUCATION. IT RESTS WITH HEALTH POLICY-MAKERS, BOTH PUBLIC AND PRIVATE, AND PHYSICIANS THEMSELVES TO DEVELOP A COHERENT MEDICAL POLICY TO ACCOMPLISH THESE GOALS.

THANK YOU FOR THE OPPORTUNITY TO SUBMIT MY VIEWS.

# # #

A REPORT

OFFICE OF THE
CITY COUNCIL
PRESIDENT

IS THERE A DOCTOR IN THE HOUSE?

HOW THE LOSS OF FOREIGN MEDICAL GRADUATES
WILL AFFECT HEALTH CARE DELIVERY IN NEW YORK CITY

CAROL BELLAMY
CITY HALL
NEW YORK, N.Y. 10007
[illegible]

FEBRUARY 1980

Acknowledgements

This report was authored by Stella Schindler, with the assistance of Barry Ensminger of the New York City Council President's Office. The author is especially grateful for expertise provided by Robert DeCresce, M.D., M.B.A., Assistant Professor of Pathology, Downstate Medical School.

We would also like to thank Council President staff members: Charles Perkins, Lynne Abraham, Denise Duchemin, Susan Solomon and Olka Harbor, for their help.

We appreciate comments provided by Charles Davenport Cook, M.D., Chief of Pediatrics, Downstate Medical Center; Harold Ratner, M.D., Chief of Pediatrics, Greenpoint Hospital; and Hugh Evans, M.D., Chief of Pediatrics, Brooklyn Jewish Hospital; as well as the cooperation of the New York City Health and Hospitals Corporation.

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Additional copies of this report may be obtained at a price of $3.50 per copy. Please forward check or money order to New York City Council President's Office, City Hall, New York, New York 10007.

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I. SUMMARY

This report focuses on a health care crisis New York City must soon face: a critical doctor shortage in municipal and voluntary hospitals because of new restrictive immigration policies for foreign-born graduates of foreign medical schools. The loss of these foreign medical graduates -- or FMG's -- will impact severely on the delivery of municipal health care services (especially in certain specialties and certain boroughs) and will have important fiscal implications for the City as well.

In 1976 Congress passed the Health Professions Educational Assistance Act, which ended a national policy of preferential treatment for FMG's seeking entry visas to the United States. At that time, FMG's represented 21 percent of the nation's physicians, many of whom worked as interns and residents in urban areas in the Northeast, particularly New York.

The consequences of the new policy did not go unnoticed. A 1978 article in the prestigious New England Journal of Medicine considered the national implications; a study by the New York State Health Planning Commission looked at the FMG situation statewide. (Some of their respective data are cited in this report.) But despite these studies, New York City took little action to confront the impending problem. This report, which has been and will continue to be used as a lobbying tool to press for recommended federal legislation, details how the doctor shortage will impact on municipal hospitals, and breaks down contemplated costs for replacement medical personnel in HHC institutions.

Attracted by New York's cosmopolitan image and the large numbers of teaching hospitals here, FMG's have traditionally concentrated in the City, working in older facilities in poor inner-city neighborhoods usually shunned by their American counterparts.

Foreign medical graduates now hold about 40 percent of all intern and resident positions in New York City. The new immigration restrictions, which take effect after December 31, 1980, are expected to ultimately cut the FMG population by two-thirds, from 3,056 in 1978 to fewer than 1,100 by 1984.

The reduction of foreign physicians will cripple some City hospitals, while barely affecting others. Large, prestigious institutions will continue to recruit the top students from American medical schools, while deficit-ridden hospitals will find their staffs cut drastically. In 12 New York hospitals, FMG's now represent more than 75% of the housestaff (interns and residents) and their departure could result in severe disruptions. The reduced pool of FMG's will cause the greatest problems in facilities run by the Health and Hospitals Corporation (HHC), which trains more than 40% of the foreign graduates in New York. The HHC dependence on FMG's will be felt more in certain specialties -- pediatrics, anesthesiology and gynecology -- and certain boroughs -- Brooklyn, Queens and Manhattan. An extreme example of the FMG loss: FMG's now make up 93% of HHC pediatricians in Brooklyn and the new policy could leave the borough without any children's services in its municipal hospitals.

One option available to HHC would be to replace FMG's with attending physicians and physician extenders, thus driving up medical personnel costs. If this course is followed, the Council President's Office conservatively estimates that costs will rise $4.4 million in 1981, $9.9 million in 1982, $15.4 million in 1983 and $21 million in 1984.

To minimize the impact of the upcoming doctor shortage, this report recommends that Congress:

- Postpone implementation of the new immigration restrictions until December 31, 1985 giving the City more time to prepare for the reduction of FMG's.

- Allow FMG's entering the country under the new restrictions to stay long enough to complete their training program (usually four to five years). The law now imposes a two year limit.

- Permit National Health Service Corps doctors to use postgraduate training as fulfillment of their service obligation. Under the current law, Corps doctors receive tuition assistance in exchange for payback service in medically-underserved areas only after training is completed. Present law also precludes any Corps service in municipal hospitals.

In addition, New York City should:

- Intensify its recruitment of American trained physicians, many of whom attended medical schools in the city.

- Step up recruitment of American graduates of foreign medical schools, many of whom are originally from New York.

- Reduce surplus housestaff positions.

II. HISTORY

Over the past two decades, foreign-born graduates of overseas medical schools have played an increasingly prominent role in the delivery of health services in the United States. They often serve in inner-city hospitals lacking doctors and enter specialties, such as pediatrics, gynecology and anesthesiology, which are frequently shunned by their American counterparts.

More than one-fourth of the nation's foreign medical graduates (FMG's) receive training in New York City, which cannot attract enough American graduates to its large number of teaching hospitals in poor and medically underserved neighborhoods.

Concerned about the nationwide shortage of doctors in the 1960's, the federal government encouraged the influx of foreign medical graduates. The usual immigration requirements were waived for foreign doctors in 1965 amendments to the Immigration and Naturalization Act. These amendments exempted foreign physicians from the national origins quota system, thus providing easier access to the United States. Between 1965 and 1975 an average of 7,375 foreign medical graduates entered the country every year, receiving valuable training in U.S. hospitals and providing essential medical services in return.[1]

Finding the lucrative earning power of American doctors hard to resist, many FMG's converted their temporary permits into permanent visas to stay in the United States. By 1976, FMG's accounted for 85,000 -- or 21% -- of the nation's 409,000 physicians. Many of these doctors set up practice in low-income neighborhoods avoided by U.S. medical graduates.

As thousands of foreign doctors stayed in the United States, their native countries felt the impact of the "brain drain". Leaders of underdeveloped countries asked why their nations should provide expensive medical school training to young men and women, only to see them leave to practice in the United States.

Most of the arriving FMG's, in fact, were from countries badly in need of their own medical personnel. Of the 10,188 foreign doctors in the U.S. training programs in 1977, 6,559 -- or 64% -- were from physician-poor Asia, and only 1,570 -- or 15% -- were from Europe, where doctors are more plentiful. Over 3,993 -- or 39% -- were from India and the Philippines alone, neither of which has an abundance of doctors.[2]

Over the past few years, the need for foreign medical graduates in the U.S. has declined, as increasing numbers of doctors graduated from American medical schools. From 1966 to 1977, a 6% annual increase in the number of U.S. graduates helped alleviate the physician shortage of the early sixties, nearly doubling the number of U.S. medical graduates.[3] Fears of physician surpluses in some sections of the country were voiced with increasing frequency.

Questions were raised as well about the medical qualifications of the FMG's. Critics pointed out that foreign doctors were not scoring as well as American graduates in standardized tests and questioned their proficiency in the English language. Language and cultural barriers often create obstacles to proper treatment and diagnosis, it was argued. Medical experts acknowledge, however, that standardized tests are not always a fair measure, since they test language proficiency and knowledge of basic medical science, rather than the clinical skills needed on a day-to-day basis. Unfortunately, no comprehensive and reliable study has ever compared the quality of medical care provided by American and foreign medical graduates.[4]

Criticism of the physician "brain drain" from other nations, the increasing supply of U.S. medical graduates and continuing concern about the quality of care rendered by foreign medical graduates convinced more and more policymakers to challenge the federal government's liberal immigration policy for doctors. A series of studies -- by the National Advisory Commission of Health Manpower, the Coordinating Council on Medical Education, the Carnegie Council on Policy Studies in Higher Education, the American Association of Medical Colleges and others -- recommended basic changes in federal policy.

III. FEDERAL LAW RESTRICTS ENTRY OF FOREIGN MEDICAL GRADUATES

Congress responded to these growing concerns by passing the National Health Professions Educational Assistance Act of 1976, declaring the United States self-sufficient in physician manpower and ending the national policy of preferential treatment for foreign medical graduates desiring entry visas.[5] The new law tightened the educational standards and visa qualifications necessary for entry in an effort to reduce dependence on foreign medical graduates and assure that those who do enter meet the same standards as American graduates. The law essentially placed foreign medical graduates on the same footing as any other alien trying to enter the country.

Specifically, the law:

1) Raises the educational requirements for entering foreign medical graduates by replacing the Educational Commission for Foreign Medical Graduates test (ECFMG) with the Visa Qualifying Examination (VQE). The new test, stressing basic medical science and English proficiency, is significantly more difficult. In 1977, when both exams were offered, 33% of the participating foreign medical graduates passed the Educational Commission for Foreign Medical Graduates exam compared with less than 25% for the Visa Qualifying Examination.

2) Imposes a two-year time limit on training programs with an optional third year if requested by the foreign medical graduate's home country. (Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.)

3) Eliminates the favored status of foreign medical graduates and the occupational preference entitling them to Immigrant Visas. Foreign medical graduates are now required to enter the United States on Exchange Visas which, unlike Immigrant Visas, cannot be converted to allow permanent residence.

Hospitals and medical schools can have the Visa Qualifying Examination requirement waived for individual training programs until December 31, 1980, if they demonstrate that a "substantial disruption in medical services" would otherwise occur.[6]

Not affected by the change in law are American graduates of foreign medical schools, since the immigration restrictions only affect the foreign-born.

IV. LOSS OF FOREIGN MEDICAL GRADUATES MOST SEVERE IN NORTHEAST AND NEW YORK CITY

The 1976 law greatly reduces the pool of foreign medical graduates eligible for entry into the United States each year, cutting the annual supply of FMG's by two-thirds -- from 7,500 to 2,500 -- by 1980 or 1981, according to a 1978 forecast by the Department of Health and Human Services (formerly Health, Education and Welfare).[7] Foreign medical graduates beginning four to five year long residency programs before December 31, 1980 will still be able to enter the country under the waiver provision. The full impact of the law, however, will not be felt until 1985, when the 1980 group will have graduated, and virtually all foreign medical graduates in the country will have entered under the stricter regulations.

The loss of FMG's will be most severely felt in the industrialized sections of the northeast and northcentral states, where hospitals have traditionally relied upon the foreign doctors.

New York City is and will continue to be particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. The City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056 -- or 38% -- were foreign medical graduates.[8]

This high proportion of FMG's stems from the problem many City hospitals face when recruiting U.S. medical graduates. Elite Manhattan hospitals can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden, inner-city hospitals have been difficult in the past and are not getting any easier. Students are uncertain about the future of New York's troubled hospitals; 27 private hospitals have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for about 40% of the interns and residents citywide, the proportion in individual voluntary and municipal hospitals ranges from 7% to 100%. Foreign medical graduates amount to more than 50% of the housestaff -- interns and residents -- in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75%.[9] Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the foreign graduates.

TABLE I:

DEPENDENCE ON FOREIGN MEDICAL GRADUATES IN NEW YORK CITY BY HOSPITAL AND INCOME OF CATCHMENT AREA FAMILIES

Hospital	Location	Catchment Area Families with income less than $5,000 a year
More than 75 Percent Foreign Medical Graduates		
Bronx-Lebanon*	Bronx	30-40%
Cumberland	Brooklyn	20-30%
Goldwater	Manhattan	less than 20%
Greenpoint	Brobklyn	more than 40%
Brooklyn-Jewish*	Brooklyn	more than 40%
Jewish Memorial*	Brooklyn	30-40%
Kingsbrook*	Brooklyn	more than 40%
Methodist*	Brooklyn	20-30%
St. Johns Esp.*	Brooklyn	more than 40%
Sydenham	Manhattan	20-30%
Catholic Medical Center*	Brooklyn	NA**
Flushing*	Queens	NA**
51-75% Foreign Medical Graduates		
Beekman*	Manhattan	more than 40%
Cabrini*	Manhattan	less than 20%
Coler	Manhattan	less than 20%
Coney Island	Brooklyn	20-30%
Elmhurst	Queens	NA**
Jamaica*	Queens	more than 40%
Veterans Administration	Bronx	NA**
Long Island College*	Brooklyn	20-30%
St. Vincent's*	Staten Island	20-30%
Lutheran*	Manhattan	30-40%
N.Y. Infirmary	Manhattan	less than 20%
26-50% Foreign Medical Graduates		
St. Luke's*	Manhattan	30-40%
Beth Israel*	Manhattan	less than 20%
Booth*	Queens	NA**
Brookdale*	Brooklyn	30-40%
Kings County/ Downstate	Brooklyn	30-40%
Harlem	Manhattan	20-30%
Staten Island*	Staten Island	20-30%
Metropolitan	Manhattan	more than 40%
Einstein*	Bronx	less than 20%
Long Island Jewish*	Queens	less than 20%
Maimonides*	Brooklyn	less than 20%
Less than 26% Foreign Medical Graduates		
Bellevue	Manhattan	less than 20%
Bronx Municipal	Bronx	less than 20%
Lenox Hill*	Manhattan	less than 20%
Mt. Sinai*	Manhattan	more than 40%
Montefiore*	Manhattan	less than 20%
New York University*	Manhattan	less than 20%
St. Vincent's*	Manhattan	30-40%
New York Hospital*	Manhattan	less than 20%
Misericordia*	Bronx	less than 20%
N.Y. Eye and Ear*	Manhattan	less than 20%
Presbyterian*	Manhattan	30-40%
Roosevelt*	Manhattan	less than 20%

Source: "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission, 1979.

*Voluntary Hospitals
**NA = Not Available

V. SERVICE DELIVERY IMPLICATIONS BY BOROUGH AND SPECIALTY

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corporation (HHC), which trains about 40% of the foreign graduates in the City.

Municipal health services in some boroughs will be more affected by the new immigration requirements than others. Brooklyn hospitals, with the oldest physical plants, are now the most reliant on foreign medical graduates, while certain Bronx hospitals with prestigious medical affiliations are the least dependent. North Central Bronx Hospital, for example, is a brand new institution affiliated with the renowned Montefiore Hospital. Bronx Municipal Hospital Center, despite its older facility, attracts American graduates through its affiliation with the Albert Einstein School of Medicine.

TABLE II:

SURVEY OF HEALTH AND HOSPITALS CORPORATION DEPENDENCE ON FOREIGN MEDICAL GRADUATES BY BOROUGH

(1979)

Borough	Total Number House Staff	Total Number FMG	Percent
Brooklyn	937	547	58.4
Queens	470	171	36.4
Manhattan	1,023	321	31.4
Bronx	784	245	31.3
Total	3,214	1,284	39.9

Source: Unpublished housestaff survey, Health and Hospitals Corporation, 1979.

While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates. More than 80% of the foreign medical graduates, for example, are in four primary care specialties -- medicine, general surgery, pediatrics, and obstetrics/gynecology -- and four non-primary care fields -- pathology, psychiatry, anesthesiology, and rehabilitative medicine. Foreign graduates now make up 93% of the Health and Hospitals Corporation's pediatricians in Brooklyn, and the new policy could leave the borough without any children's services in the municipal hospitals.

The shortage of anesthesiologists throughout the City is already so severe that Dr. Joseph Giuffrida, Chief of Service at Manhattan's Metropolitan Hospital, warns that at Metropolitan "the Department of Anesthesiology wishes to go on public record that it cannot take responsibility for the lack of proper patient care."[10]

The extent of HHC's dependence on foreign graduates is detailed by borough and specialty in the following tables:

TABLE III:

DEPENDENCE OF HEALTH AND HOSPITALS COROPORATION ON FOREIGN MEDICAL GRADUATES BY SPECIALTY AND BOROUGH (1979)

Borough	Specialty	# of House Staff	# of FMG	Percent
Brooklyn				
	Surgery	140	86	61.4
	Pediatrics	121	112	92.6
	Pathology	36	32	88.9
	Obs/Gyn	78	47	60.1
	Medicine	355	183	51.5
	Psychiatry	45	17	37.8
	Anesthesiology	16	14	87.5
Manhattan				
	Surgery	101	66	65.3
	Pediatrics	111	53	47.7
	Pathology	41	13	31.7
	Obs/Gyn	92	20	21.7
	Medicine	266	15	5.6
	Psychiatry	110	33	30.0
	Anesthesiology	49	33	67.3
	Rehab. Medicine	45	38	84.4
Queens				
	Surgery	34	8	23.5
	Pediatrics	62	24	38.7
	Pathology	21	20	95.2
	Obs/Gyn	21	3	14.2
	Medicine	146	28	19.2
	Psychiatry	72	36	50.0
	Anesthesiology	-	-	-
	Rehab. Medicine	17	14	82.3
Bronx				
	Surgery	69	18	26.0
	Pediatrics	112	25	22.3
	Pathology	17	6	35.3
	Obs/Gyn	49	22	44.8
	Medicine	203	58	28.5
	Psychiatry	66	14	21.2
	Anesthesiology	35	30	85.7
	Rehab. Medicine	18	16	88.8
	Specialty Totals	2,548	1,084	42.5

TABLE IV:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN BRONX HOSPITALS (1979)

Hospital	Total # Staff	FMG	%	Specialty	# House Staff	# FMG	%
Bronx Municipal	466	96	20.6	Surgery	41	0	0.0
				Pediatrics	54	3	5.6
				Pathology	13	4	30.8
				Obs/Gyn	24	3	12.5
				Medicine	89	2	2.2
				Psychiatry	47	2	4.3
				Anesthesiology	30	25	83.3
				Rehab. Medicine	13	11	84.6
Lincoln	176	135	76.7	Surgery	22	18	81.8
				Pediatrics	31	31	100.0
				Pathology	2	2	100.0
				Obs/Gyn	20	18	90.0
				Medicine	60	56	93.3
				Psychiatry	12	11	91.6
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
North Central	142	14	9.9	Surgery	6	0	0.0
				Pediatrics	27	1	3.7
				Pathology	2	0	0.0
				Obs/Gyn	5	1	20.0
				Medicine	54	0	0.0
				Psychiatry	7	1	14.3
				Anesthesiology	5	5	100.0
				Rehab. Medicine	4	4	100.0
TOTALS	784	245	31.3				

TABLE V:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN BROOKLYN HOSPITALS (1979)

Hospital	Total # Staff	Total # FMG	%	Specialty	# House Staff	# FMG	%
Cumberland	172	145	84.3	Surgery	34	28	82.4
				Pediatrics	32	28	87.5
				Pathology	11	9	81.8
				Obs/Gyn	22	17	77.2
				Medicine	70	63	90.0
				Psychiatry	NA	NA	-
				Anesthesiology	NA	NA	-
Greenpoint	144	119	82.6	Surgery	26	22	84.6
				Pediatrics	36	32	88.9
				Pathology	-	-	-
				Obs/Gyn	22	18	81.8
				Medicine	48	36	75.0
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
Kings County	538	221	41.1	Surgery	72	28	38.9
				Pediatrics	51	50	98.0
				Pathology	19	17	89.5
				Obs/Gyn	31	10	32.2
				Medicine	173	40	23.1
				Psychiatry	45	17	37.8
				Anesthesiology	16	14	87.5
Coney Island	83	62	74.7	Surgery	8	8	100.0
				Pediatrics	2	2	100.0
				Pathology	6	6	100.0
				Obs/Gyn	3	2	66.7
				Medicine	64	44	68.8
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
TOTALS	937	547	58.4				

TABLE VI:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN QUEENS HOSPITALS (1979)

Hospital	Total # Staff	Total # FMG	%	Specialty	# House Staff	# FMG	%
Queens	330	82	24.8	Surgery	34	8	23.5
				Pediatrics	45	8	17.8
				Pathology	12	11	91.7
				Obs/Gyn	21	3	14.3
				Medicine	78	6	7.7
				Psychiatry	42	7	16.7
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
Elmhurst	140	89	63.6	Surgery	-	-	-
				Pediatrics	17	16	94.1
				Pathology	9	9	100.0
				Obs/Gyn	-	-	-
				Medicine	68	22	32.3
				Psychiatry	30	29	96.6
				Anesthesiology	-	-	-
				Rehab. Medicine	16	13	81.2
TOTALS	470	171	36.4				

TABLE VII:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN MANHATTAN HOSPITALS (1979)

Hospital	Total # Staff	FMG	%	Specialty	# House Staff	# FMG	%
Harlem	261	122	46.7	Surgery	74	50	67.6
				Pediatrics	26	23	88.5
				Pathology	9	9	100.0
				Obs/Gyn	38	16	42.1
				Medicine	84	2	2.4
				Psychiatry	23	18	78.3
				Anesthesiology	1	1	100.0
Metropolitan	222	92	41.4	Surgery	27	16	59.3
				Pediatrics	23	15	65.2
				Pathology	-	-	-
				Obs/Gyn	17	3	17.6
				Medicine	65	7	10.8
				Psychiatry	30	13	43.3
				Anesthesiology	15	15	100.0
				Rehab. Medicine	5	5	100.0
Bird S. Coler	18	12	66.7	Surgery	-	-	-
				Pediatrics	2	2	100.0
				Pathology	-	-	-
				Obs/Gyn	-	-	-
				Medicine	6	2	33.3
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
				Rehab. Medicine	6	6	100.0
Bellevue	517	95	18.4	Surgery	NA	NA	-
				Pediatrics	60	13	21.7
				Pathology	32	4	12.5
				Obs/Gyn	37	1	2.7
				Medicine	111	4	3.6
				Psychiatry	57	2	3.5
				Anesthesiology	33	17	51.5
				Rehab. Medicine	34	27	79.4
TOTALS	1,018	321	31.5				

In sum, if the Department of Health and Human Services prediction of a two-thirds reduction of foreign medical graduates nationally holds true for New York City, the Health and Hospitals Corporation will lose more than 800 physicians by 1984 --one-half the HHC housestaff in pediatrics, child psychiatry, general surgery and obstetrics/gynecology. These loses will jeopardize the delivery of health services where the dependence on foreign medical graduates is most acute, especially at Cumberland, Greenpoint, Lincoln, Kings County, and Elmhurst hospitals.

Moreover, there is the strong possibility that HHC hospitals will lose more than the two-thirds reduction projected for the entire country. As the nationwide pool of foreign medical graduates shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Financial problems and outdated facilities already put municipal hospitals at a disadvantage. Applications for internships and residencies at HHC hospitals dropped 8% between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported fall offs from 25% to 75%.[11] New York's difficulties in recruiting physicians only will be compounded by the immigration restrictions.

VI. HEALTH AND HOSPITALS CORPORATION MEDICAL PERSONNEL COSTS INCREASE

The reduction of foreign medical graduates will force the Health and Hospitals Corporation -- in the short run at least -- to replace foreign graduates with more costly attending physicians and physician extenders (non-physician providers such as nurse practitioners, who perform medical tasks under the supervision of a doctor).

Replacing lost housestaff will be expensive for the Health and Hospitals Corporation. Interns and residents are a bargain for teaching hospitals. In exchange for training, they routinely work 70 to 90 hours a week and are paid less than half the salary of an attending physician.

Replacement costs will rise each year from 1980 to 1985, as increasing numbers of foreign medical graduates are affected by the new law and the expiration of the waiver provision. In 1981, only first year housestaff will be affected by the restrictions; upper level positions will continue to be occupied by foreign medical graduates already in the United States. By 1985, all levels of housestaff will be affected, and the foreign medical graduate pool will have been greatly reduced.

If the FMG reduction begins to disrupt hospital training programs, upper-level interns and residents may decide to move to more stable institutions. This would further undermine the viability of entire departments, jeopardizing still more health services.

Analysis by the Council President's Office indicates that in the four primary care specialties alone -- pediatrics, obstetrics/gynecology, medicine and surgery -- replacement costs for foreign medical graduates in Health and Hospitals Corporation hospitals will be at least $4.4 million in 1981. All cost estimates in this report assume that 75% of the foreign medical graduates now filling the 204 entry level positions are replaced by physician extenders and attending physicians, and that HHC will actually be able to find replacement personnel.

In 1982, when first and second year housestaff are affected, costs will rise proportionately, because more attending physicians will be needed to compensate for the greater responsibilities of second year interns and residents. Total replacement costs for the primary fields: $9.9 million.

Primary care replacement will continue to escalate in succeeding years, reaching $15.4 million in 1983 and $21 million in 1984.*

All these figures are conservative and none take into account the additional expense of replacing the non-primary care specialists, nor doctors in voluntary hospitals. Since it was not clear how many personnel will have to be replaced in the non-primary care fields, the added costs of hiring housestaff in pathology, rehabilitative medicine, anesthesiology and psychiatry were not included in this report.

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*For an explanation of the cost methodology see Appendix

Nor do these estimates reflect added costs to state mental health hospitals which are also heavily dependent on foreign medical graduates. In the five state institutions based in New York City, nearly all psychiatric residents are FMG's. The Director of Medical Education at Kingsboro Psychiatric Center reports a severe recruitment problem already and predicts that "patient care will suffer in the future because we will not have enough physicians."

VII. RECOMMENDATIONS

A. Short Term Recommendation

Although the new FMG policy is certain to drive up expenses in City hospitals, several steps should be taken to minimize the additional costs.

In the short run, Congress must extend the phase-in period of the law from December 31, 1980 to December 31, 1985, allowing the federal government to continue granting waivers to avoid a "substantial disruption of health services."

The present waiver provision went into effect in 1978. Between 1978 and today, New York City has increasingly relied on waivers to fill housestaff positions in primary care, according to Magdalene Miranda, Chief of the International Education Program, Health Resources Administration, which administers the waiver program.

	Waivers Approved	
Year	National Totals	New York City Only
1978	18	9
1979	110	81
Jan. 1980	17	17
Feb. 1980	96 pending	95 pending

Extension of the waiver deadline would give the Health and Hospitals Corporation and many affected voluntary hospitals more time to prepare for the reduction of available foreign medical graduates. It must be pointed out that until recently, the hospital community in New York City -- including the Corporation -- had not used the time already allowed by the federal government to seek replacements for foreign graduates. As a result, Henry Foley of the federal Health Resources Administration expressed "concern that alternatives for meeting the future needs of the educational/service programs have not been adequately addressed" by the Corporation.[12]

Representatives of the Council President's Office, the Corporation and Chiefs of Service of the affected municipal hospitals have subsequently met with Dr. Foley to respond to his comments. The Corporation has made a commitment to present a working plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of qualified foreign medical graduates. It is generally agreed that a suitable plan must be a part of, or a predicate to, the waiver application of any hospital, public or voluntary, if the waiver period is extended.

B. Long Term Recommendations

Extension of the waiver exemption until 1985 will, in and of itself, do nothing to solve the underlying problems created by the reduced availability of foreign medical graduates. Long term solutions must be found and implemented to insure the continued provision of essential medical services, particularly in the primary care specialties:

1. Coordinate length of foreign medical graduate's stay in United States with length of training program. The law as presently written imposes a two-year time limit on training (with an optional third year if requested by the foreign medical graduate's home country). After that, the physician must leave the United States, even if the training program has not been completed. Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.

Alien physicians who come to the United States for graduate medical education and who otherwise qualify for entry should be allowed to remain for a period equal to the length of their program. This would permit foreign medical graduates to return home with the appropriate skills. Medical care would not be compromised by shortages of upper-level resident physicians, created by the forced departure of foreign medical graduates after two years.

2. Include municipal and voluntary hospital training programs in National Health Service Corps service commitment. The National Health Service Corps program provides scholarships to medical students in return for a service commitment in medically-underserved areas. But current law bars these physicians from counting any portion of their training as interns or residents towards fulfillment of their service obligation, and also precludes any Corps service in municipal hospitals.

The law should be amended to allow participation in designated training programs in voluntary and municipal hospitals to fulfill the physician's service obligation. Programs should be designated only: (1) if they involve primary care specialties in medically underserved areas such as Brooklyn and (2) are in hospitals currently dependent on foreign medical graduates for the provision of care.

There are several advantages to this approach. First, the National Health Service Corps physicians would provide essential services to medically underserved communities while continuing their medical education. Since many physicians end up practicing medicine in the community where they are trained, this amendment will help retain doctors in underserved areas. Second, it would reduce the direct cost of the program to the Federal government since the trainee would be paid by the teaching hospital rather than Washington, D.C.

3. Intensify recruitment of United States medical graduates. In 1978, 1,132 of the more than 14,000 graduates of U.S. medical schools were from schools located in New York City. More than half the local graduates stayed in the City for their postgraduate training, but only 30 percent of these entered the municipal system.

Recruiting more United States medical graduates to fill housestaff positions formerly held by foreign medical graduates will not be easy. Attracting graduates means reversing the competitive disadvantage of HHC hospitals. The uncertainties created by municipal hospital closings, and well-publicized shortages of nurses, medical supplies and equipment make this unlikely for most HHC hospitals. The best opportunity is in Brooklyn, where the foreign medical graduate problem is the greatest.

A successful July 1981 opening of Woodhull Hospital in Brooklyn, coupled with the closing of aging and substandard Greenpoint and Cumberland Hospitals and a 170-bed reduction at overcrowded Kings County Hospital, should greatly improve the attractiveness of the Brooklyn housestaff training programs. Woodhull's new physical plant and its direct affiliation with Downstate Medical School hopefully will lead many more highly qualified applicants to apply for housestaff positions, despite Woodhull's obvious planning and design flaws in this age of austerity.

Opening a 640 bed hospital successfully is a complex process and depends on many interrelated actions taking place in concert. Without proper preparation, Woodhull is likely to open late or haphazardly, greatly diminishing its potential to recruit. To take full advantage of the recruiting opportunity presented by Woodhull, the Corporation must implement the innovative medical programs now planned for the facility.

4. Step-up recruitment of American-born foreign medical graduates. Enrollment in foreign medical schools has become increasingly attractive for Americans who want to study medicine and cannot get into U.S. schools. The American Association of Medical Colleges conservatively estimates there are 6,000 such students studying throughout the world.[13] Recruiting more U.S. graduates of foreign medical schools offers real potential for replacing foreign-born FMG's.

At present, about 7 percent of HHC housestaff positions are filled with American graduates of foreign medical schools.[14] Since many U.S. foreign medical graduates are from the New York metropolitan area, local hospitals can offer not only graduate education but also the opportunity to be near families and friends after many years away.

To enlist more of these students, the Corporation should develop outreach programs to attract the most qualified. "Fifth Pathway" programs must also be expanded. These programs were developed because several foreign medical schools -- particularly those in Mexico -- require an additional year or more of clinical training after completion of formal course work, but before the awarding of a medical degree. Students considered this unreasonable since the training was often conducted with little or no supervision. The "Fifth Pathway" permits a year of clinical training, under the supervision of an American medical school, to replace the required training in Mexico and other countries. Successful completion of this year allows entry into graduate training programs, without the necessity of certification by the Educational Commission for Foreign Medical Graduates or actual possession of the medical degree.

5. Reduce surplus housestaff positions. Some foreign medical graduates are filling positions in specialties that exist more for teaching purposes than for patient needs. Likewise, some specialty services now offered in a number of municipal and voluntary hospitals could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

The Corporation should undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting the delivery of services to reduce the number of graduate physicians needed.

In reality, any strategy to reduce dependence on foreign physicians must employ a combination of these options in order to succeed. For too long, HHC has not had to compete for quality personnel because of the ready availability of FMG's. That time has passed. A plan -- with firm targets for implementation -- must now be devised to replace these physicians, especially in the primary care specialties.

VIII. CONCLUSION

The previous pages document the critical doctor shortage New York City must confront over the next few years, particularly in municipal and voluntary hospitals in inner-city neighborhoods. This report makes specific short and long range recommendations to help the City cope with what could be a serious health care delivery crisis.

But lost in this debate is the larger issue of maldistribution -- by specialty and geography -- of physicians trained here in the United States.

With educational priorities in American medical schools stressing diagnosis and treatment of exotic illnesses over day-to-day delivery of basic medical services, it is not surprising that many medical students opt for such over-subscribed specialties as neurosurgery and tropical medicine, rather than such badly needed primary care fields as family practice and pediatrics.

And, lured by the financial rewards offered by affluent urban areas and suburbs, not enough physicians elect to serve in the inner-city. In most areas of the Bronx, for example, one doctor is available for every 10,000 people, as contrasted with a statewide ratio of one doctor for every 405 people. Residents of poor neighborhoods depend on hospital outpatient and emergency room service for primary care. As the Chief of Pediatrics at Greenpoint Hospital put it: "Interns and residents are the family doctors of the poor." And in many municipal hospitals today, that intern or resident is likely to be foreign-born.

One might say that the fact there is a need for this study and its recommendations is a sad commentary on the American medical profession today. For stop-gap legislation regarding the FMG cutoff is not the answer. Redistributing medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class, depends on reordering the priorities of American medical education. It rests with health policy-makers, both public and private, and physicians themselves to develop a coherent medical manpower policy to accomplish these goals.

APPENDIX

COST METHODOLOGY FOR REPLACING FOREIGN MEDICAL GRADUATE HOUSESTAFF WITH ATTENDING PHYSICIANS AND PHYSICIAN EXTENDERS

A number of assumptions were used to estimate the replacement costs should unfilled housestaff positions result from the full implementation of P.L. 94-84. These assumptions were made conservatively due to the inherent uncertainty of forecasting the Corporation's ability to recruit from the reduced pool of FMG's, as well as the wide variation in individual training programs at HHC hospitals. Since the delivery of necessary health services -- not lost educational opportunities -- are the major concern, only the costs of replacing direct patient care activities were considered.

Data as to the number of foreign medical graduates in entry and intermediate level housestaff positions were obtained from the 1978 Health and Hospitals Corporation Housestaff Survey and Findings, since the 1979 survey was not categorized by year of training. No significant changes in personnel, however, have occurred between 1978 and 1979.

In 1978, FMG's occupied 132 of the 277 entry level positions in the non-primary care specialties (pathology, anesthesiology, psychiatry, and rehabilitative medicine) and 480 of the 1,064 positions at all levels. No replacement costs were calculated for these specialties since a large portion of physician time is spent on education-related activities, not patient care. (It is clear, however, for the same reasons outlined below, that replacement costs for patient care activities performed by these specialists will be higher.)

In the primary care specialties (pediatrics, obstetrics/gynecology, medicine and surgery), foreign medical graduates occupied 204 of the 536 entry level positions and 642 of the 1,551 positions at all levels. Replacement costs were calculated for these specialties only -- because most physician time is spent on direct patient care.

A. Assumptions and Methodology

1. Entry level housestaff (PGY-I) work an average of 80 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 72 hours per week.

2. Intermediate level housestaff (PGY-II and III) work an average of 72 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 65 hours per week.

3. It was assumed that all service hours are necessary for patient care.

4. Replacement providers (physician extenders and attending physicians) work a standard 40-hour week.

5. Entry level housestaff (PGY-I) could be replaced on a one-to-one basis by physician extenders. Supervision by attending physicians, equal to one attending for every ten physician extenders, would be necessary to assure adequate quality of care.

946

6. Intermediate level housestaff (PGY-II and III) could be replaced by 0.5 physician extender and 0.5 attending physician. (This probably understates physicians duties, underestimating additional costs.)

7. Physician extenders were considered to be salaried at $25,000 a year ($20,000 plus 25 percent fringe benefits). Attending physicians were considered to be salaried at $50,000 a year ($40,000 plus 25 percent fringe benefits). Housestaff were considered to be salaried at $25,000 a year ($20,000 plus 25% fringe benefits). While current starting salaries for housestaff and physician extenders are in fact lower than those cited above, these averages include adjustments for seniority and inflation over the next three years.

B. Individual Housestaff Replacement Costs

1. For each unfilled first-year housestaff position, the additional replacement cost is $29,000

1.80 physician extenders X $25,000 = $45,000
.18 attending physicians X $50,000 = $ 9,000
$54,000

($54,000 - $25,000 unpaid housestaff salary = $29,000)

2. For each unfilled intermediate level (PGY-II and III) housestaff position, the additional replacement cost is $35,900

0.812 physician extenders X $25,000 = $20,300
0.812 attending physicians X $50,000 = $40,600
$60,900

($60,900-$25,000 unpaid housestaff salary = $35,900)

C. Estimated Additional Costs-By Year

1981

In 1981, only first year housestaff will be affected by the elimination of the waiver since upper level positions are filled with foreign medical graduates already admitted to the United States under the old restrictions. Assuming 75 percent of the 204 entry level positions will have to be replaced by physician extenders and supervising attending physicians, the additional cost will be $4.4 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

1982

In 1982, both first and second year housestaff will be affected by the elimination of the waiver. Third year housestaff positions will still be filled with foreign medical graduates admitted to the United States under the old restrictions. Assuming all first year housestaff are promoted and assuming 75% of the first and second year positions will have to be replaced, the additional cost will be $9.9 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

153 second year position X $35,900 replacement cost per position = $5.5 million

1983

In 1983, first, second and third year housestaff will be affected by the elimination of tne waiver. Assuming all first and second year housestaff are promoted, and assuming that only 75% of the third year positions will have to be replaced, the additional cost will be $15.4 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

153 second year positions X $35,900 replacement cost per position = $5.5 million

153 third year positions X $35,900 replacement cost per position = $5.5 million

1984

In 1984, first, second, third and fourth year housestaff will be affected by elimination of the waiver. All housestaff are promoted, and assuming only 75% of the fourth year portions will have to be replaced, the actual cost will be $21 million in 1984.

153 first year positions X $35,900 replacement cost per position = $4.4 million

153 second year positions X $35,900 replacement cost per position = $5.5 million

153 third year positions X $35,900 replacement cost per position = $5.5 million

153 fourth year positions X $35,900 replacement cost per position = $5.5 million

FOOTNOTES

1. Update Report on Foreign Medical Graduates in the United States, Department of Health, Education, and Welfare, 1977, Table IV.
2. "Annual Report on Medical Education in the United States, 1977-1978", Journal of American Medical Association, 240: 2837-2846 (1978).
3. "Foreign Medical Graduates and the Issue of Substantial Disruption of Medical Services", New England Journal of Medicine, 299: 745-751 (1978).
4. "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission (1979).
5. Title VI, P.L. 94-484, October 12, 1976, 90 Stat. 2243, as amended by P.L. 95-83, August 1, 1977, 91 Stat. 383.
6. Ibid.
7. New York State Health Planning Commission, op. cit.
8. Ibid.
9. Ibid.
10. July 24, 1979 memorandum from Dr. Joseph E. Guiffrida to Dr. Camille Mallouh, President, Medical Board, Metropolitan Hospital.
11. New York State Health Planning Commission, op. cit.
12. July, 1979 letter from Henry Foley, Ph.D., Administrator, Health Resources Administration, to Mr. Jack Koretsky, Executive Vice President, Health and Hospitals Corporation

13. "Career Choice and Performance on State Licensing Examinations of 'Fifth Pathway' Students", New England Journal of Medicine, 299: 227-250 (1978).

14. Health and Hospitals Corporation Housestaff Study and Findings, published May, 1978.

aota
The American Occupational Therapy Association, Inc.

March 25, 1980

The Honorable Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
Committee on Labor and Human Resources
4220 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

On behalf of the American Occupational Therapy Association and its 29,000 members, I welcome the opportunity to offer testimony in conjunction with your hearings on the reauthorization of the health manpower legislation. I would request that this letter and the accompanying statement be incorporated into the record of these hearings.

Occupational therapists are among those health professionals traditionally categorized in Title VII of the Public Health Service Act as "allied health". The "allied health" professionals currently constitute a sizable portion of the total 5 million person health care workforce, 20 percent by conservative estimates and well over 50 percent by others. Despite this substantial dependence of the health care delivery system on "allied health" personnel, the Federal government has consistently failed to provide adequate support for "allied health" education. From 1965 - 1976 the Federal government spent $4.2 billion on the education of health professionals. Of this amount, only $183 million, or 4 percent of the total, supported "allied health" programs. The inequity of these allocations is patently obvious. More alarming,however, is the fact that without increased government assistance "allied health" educational programs may soon no longer be able to meet the rising demand for more "allied health" practitioners. As the delivery system begins to experience the effect of "allied health" personnel shortages, the real impact of government neglect of "allied health" education will be demonstrated.

Recent studies, published by the Department of Health, Education and Welfare and the Department of Labor, indicate the rising demand for more "allied health" personnel. Prior to these reports, there existed a widely-held assumption there were no personnel shortages among health professionals. The only problem was maldistribution. Usually studies of physician supply and demand were cited as support for these conclusions. The conclusions were equally, and rather glibly, applied to all health professions, including "allied health" professionals, on the false assumption that what applied for physicians must also hold true for other health professionals. Data to support this sweeping application was never presented.

With regard to occupational therapists, one would be hard-pressed to find such data, since none exists. On the contrary, as I describe in my statement, current evidence indicates that there are now severe shortages of occupational therapists and that these shortages will continue throughout the present decade. I seriously urge that this information be given careful consideration and attention, as you develop new legislation in this area.

I would also point out that the personnel shortages among occupational therapists are directly related to the educational system. At the present time, occupational therapy educational programs are forced to turn away between one-third and one-half of the qualified students who apply. These students cannot be accepted because there are neither sufficient numbers of faculty nor adequate space to provide for their education, and because the spiraling cost of a college education prohibits many interested and competent young people from pursuing a career in occupational therapy. There is, therefore, an urgent need for increased Federal assistance for faculty development, space improvements, and student support. This need certainly exists for occupational therapists, and I would suspect that it would also apply to many other of the "allied health" professions.

Occupational therapists, together with other "allied health" professionals, play a crucial role in the delivery of health care services. Their efforts are directed toward increasing the independence of individuals with physical, psychological, or developmental disabilities. An occupational therapist's success with a patient means, among other things, that the individual will no longer be dependent on continuing costly care. In some instances, it further means that the individual will be able to return to wage earning employment. In both situations, important subsidiary benefits of the occupational therapist's services are frequently the cost savings effected for the total health care system and the additional revenue production resulting from renewed employment.

I would also point out, moreover, that when the Federal government supports the education of an occupational therapist, it is not contributing to the development of a health professional who will one day fall into the upper tax brackets. At the present time, the average annual salary for occupational therapists is approximately $15,000. The top brackets for supervisory occupational therapy personnel are between $21,000 and $24,000. Only 5 percent of the working profession falls into this top category. Support for occupational therapy education, then, could hardly be subject to the complaint that the government is unnecessarily subsidizing a wealthy profession.

As you and your Subcommittee go about the task of developing new health manpower legislation, Mr. Chairman, I strongly urge you to provide appropriate and adequate provision for the education of occupational therapists and other "allied health" professionals. The continuation of their important contributions to the provision of quality and cost-effective health care depends heavily upon the Federal government's support of their educational programs. Let your legislation ensure that this support is forthcoming.

In presenting this testimony, I also express my agreement with, and support for, the views expressed by the American Society of Allied Health Professions and the Coalition of Independent Health Professions.

Sincerely,

James J. Garibaldi

James J. Garibaldi
Executive Director

JJG:dcd
Attachment

aota
The American Occupational Therapy Association, Inc.

STATEMENT

OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

ON

LEGISLATION RELATED TO THE

EDUCATION OF HEALTH PROFESSIONALS
(TITLE VII OF THE PUBLIC HEALTH SERVICE ACT)

SUBMITTED TO

SUBCOMMITTEE ON HEALTH & SCIENTIFIC RESEARCH

COMMITTEE ON LABOR AND HUMAN RESOURCES

U. S. SENATE

MARCH 25, 1980

6000 Executive Boulevard Rockville, Maryland 20852 (301) 770-2200

For over 60 years the American Occupational Therapy Association (AOTA) has represented health professionals who specialize in increasing the independent functioning and productivity of people of all ages who are physically, psychologically, or developmentally disabled. Occupational therapists work in a wide variety of settings using rehabilitation techniques to reduce pathology or impairment and help their clients achieve a maximal level of independence. Occupational therapists are committed to the belief that a health system which provides the best medical intervention in the world to save a life is incomplete if it does not include services to help ensure that the life which has been saved will be meaningful and productive.

Throughout its history, occupational therapy has been concerned with the prevention of disability. Therapists have traditionally concentrated in large measure on the healthy factors of the people with whom they work. Occupational therapists attempt to mobilize areas of "wellness" in the individual or society as a primary means of creating or maintaining good health. Their orientation is towards treatment of the whole person; their concern is to help the person develop awareness of the parts of his being which are well.

Occupational therapists believe that society has a moral obligation to provide comprehensive services to ensure that an individual's right to live with dignity, and to find meaning and satisfaction in living, is maintained.

In order to fulfill this obligation, society must, among other things, provide that sufficient numbers of qualified health professionals are available to serve its members. Occupational therapists are constantly made aware of what can happen when proper and timely treatment is not available. Unnecessary and lengthy stays in hospitals and nursing homes, forms of patient regression which require a return to more intensive care, rapid progression of a disease or debilitating condition which could have been prevented, all are examples of what can occur when no qualified person is available to provide needed treatment.

It is for this reason, then, that the American Occupational Therapy Association watches, with great concern, Congress' rewriting of the health manpower legislation. There is an increasing need for more occupational therapists. This need stems, in some part, from the establishment of Federal programs which mandate the services of occupational therapists or create the expectation that these services will be available if needed. The AOTA, therefore, looks to the Congress and the Federal government for assistance in assuring that competent occupational therapists will be educated and trained.

A review of the present personnel situation in the field of occupational therapy reveals existing shortages, increasing demand for more therapists, and an inability of the current educational system to produce sufficient numbers of therapists to meet either present or future demands. The remainder of this statement will address the specific data supporting this general overview and include recommendations for Federal legislative action.

Occupational Therapy: Supply and Demand

In recent years data collected from a variety of diverse sources clearly indicates that the current supply of occupational therapists fails to meet existing demand.

- Critical shortages of occupational therapists now exist in long-term care facilities. The 1975 "Long-Term Care Facility Improvement Study" of the Department of Health, Education and Welfare (DHEW) reported that 35 percent of the people in nursing homes need occupational therapy services and only 10 percent are receiving them. Moreover, a 1977 DHEW survey of nursing homes reported that 23 percent of the full-time occupational therapists positions were vacant.

- The Bureau for the Education of the Handicapped (DHEW) reports that a 1978 survey of state school systems showed that 1,700 occupational therapists were employed during Fiscal Year 1978 and that 2,400 occupational therapists would be needed for Fiscal Year 1979. This represents an increase of approximately 40 percent.
- Three of the nine state-operated MEDIHC (Military Experience Directed Into Health Careers) programs, which place "allied health" personnel in shortage areas and occupations, listed occupational therapy as a shortage occupation in their states in 1978.
- A 1979 survey of state occupational therapy associations, conducted by the American Occupational Therapy Association, indicates that in 58 percent of the states, local job placement services reported that there were more jobs than available personnel. A number of state-operated manpower programs have found the same situation. The State of Maryland, for example, reports that 35 out of 100 budgeted positions in the State Department of Health and Mental Hygiene are currently vacant.

Future projections, moreover, reveal that this demand will continue to increase at an even more rapid rate.

- In May, 1980 the Bureau of Labor Statistics (BLS) of the Department of Labor (DOL) will publish projections of growth for different occupations in "Occupational Projections and Training Data" (Bulletin 2058). BLS projects that over the next ten years there will be an average of 2,500 openings for occupational therapists each year, consisting of 1,300 new and 1,200 replacement openings.

This represents a 100 percent increase in demand for occupational therapists, a greater increase than for any other occupation or profession studied. As noted below, the capabilities of the present educational system fall far short of meeting this increased demand.

The recently published "Report on Allied Health Personnel" (DHEW, 1980), also identifies several other factors that "will probably cause the demand for occupational therapy personnel to increase in the future." Cited among these factors were the following:

"1) An increasing proportion of the population is reaching 65 years of age. The impact of chronic disabling medical ailments such as arthritis and stroke, therefore, will create a greater demand for occupational therapy services.

2) The passage of P.L. 94-142, the Education for All Handicapped Children Act of 1975, will undoubtedly increase the demand for occupational therapy personnel. This Act requires each state to ensure that a "free and appropriate education" is available to all handicapped children between the ages of 3 and 18 by September 1, 1978, and to such children between the ages of 3 and 21 by September 1, 1980.

3) Expansion of programs under the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (P.L. 95-602) will no doubt further increase the demand for occupational therapists. These amendments changed the definition of developmental disabilities from a short list of diagnoses to a functional definition. Title III, involving the Comprehensive Services for Independent Living Program, provides for the payment

of services such as occupational therapy to those clients who can, through these services, increase their level of independence, even though they have no vocational potential or goal."

In the context of all these indicators of a present and continually increasing demand for occupational therapists, it should be noted that over the past decade the employment rate of occupational therapists has remained fairly constant -- about 78 to 80 percent -- while the numbers of therapists have increased at a rate of approximately 10 percent per year. Although each year there are more occupational therapists, there is also more than sufficient demand to absorb the increased numbers. The vast majority of the unemployed, moreover, are those who have retired or chosen to leave the work force for personal reasons, e.g., to remain at home during their children's early years. This latter characteristic could be expected in a profession, 95 percent of which is made up of women.

This increasing demand for occupational therapists, moreover, has gradually outstripped the capacities of the educational system, as a review of this system will indicate.

Occupational Therapy Educational System

Occupational therapy educational programs exist in 55 colleges and universities throughout the country. All of these programs are accredited jointly by the American Medical Association and the American Occupational Therapy Association. This accreditation system has operated since 1934.

Occupational therapists are required to complete either a four-year baccalaureate degree program, or a two-year certificate program or a two-year master's degree program following achievement of a baccalaureate degree in another field.

Six to nine months of supervised clinical experience follows completion of the academic preparation. The occupational therapist must then pass the national Certification Examination for Occupational Therapist, Registered.

Occupational therapy assistants must complete a two-year post-secondary course of study in a program approved by the American Occupational Therapy Association, undergo six to nine months of supervised clinical experience, and pass the national Certification Examination for Certified Occupational Therapy Assistants. There are 43 approved assistant level programs in colleges and junior colleges throughout the country.

A Career Mobility Program also exists for Certified Occupational Therapy Assistants who wish to become Occupational Therapists, Registered without completing the full Occupational Therapist, Registered academic program. The requirements of this program are:

- four years of employment as a Certified Occupational Therapy Assistant, six to nine months of supervised clinical experience at the Occupational Therapist, Registered level, and
- successful completion of the national Certification Examination for Occupational Therapist, Registered.

Beyond the entry level to the profession, there are also 16 master's and two Ph.D. programs in occupational therapy.

Occupational therapists and occupational therapy assistants are certified by the American Occupational Therapy Association. This national certification system, which was begun in 1934, is the only certification system for occupational therapists and assistants. Licensure laws governing the practice of occupational therapy have been enacted in 14 states, the District of Columbia, and Puerto Rico. All of these laws incorporate the same educational, clinical experience, and examination requirements as make up the AOTA certification system.

As noted above, over the past ten years the occupational therapy educational system has been somewhat capable of keeping pace with the growing demand for occupational therapists' services, although not to the point where current shortages could be eliminated. In recent years, however, the inability of the system to match the rapidly increasing demand has become readily apparent. Given the projections for the future, moreover, it is quite clear that unless the system is substantially expanded, the demand for occupational therapists will never be met.

As was cited above, the Bureau of Labor Statistics (BLS) projects 2,500 openings for occupational therapists each year through 1990. Under present conditions, the occupational therapy educational system provides to the work force approximately 1,700 new therapists each year, thereby leaving a shortage of 800 therapists, about 50 percent, per year.

By 1990, therefore, a shortage of close to 8,000 occupational therapists can reasonably be expected. This shortage could only be offset if the educational system were to grow at a rate similar to that experienced in the early 1970's. In fact, however, the growth rate of this system over the past several years has been zero.

The basic needs of the occupational therapy educational system, which must be met to remedy the current and future supply problems, can easily be identified. At the present time, close to 50 percent of the qualified applicants for admission to occupational therapy programs must be rejected because there is neither sufficient faculty nor adequate space to carry out the educational process. A secondary reason for the failure to educate more qualified therapists relates to the high cost of post-secondary and graduate education.

Over the past four years, the numbers of faculty in occupational therapy education programs has remained constant. Over the last five years student enrollments in these programs have increased by only 4.2 percent. Since 1976, only six new educational programs have been opened. Existing occupational therapy programs have reached saturation, with the numbers of graduates leveling off at approximately 1900 for each of the last several years.

All of this evidence clearly indicates that if the occupational therapy educational system is not expanded, the current gap between supply and demand will widen dramatically. The educational system holds the key to resolving this supply problem. If support can be furnished to increase faculty to provide more adequate space, to assist with student tuition and other costs, and to aid in the development of new programs, then sufficient numbers of qualified occupational therapists can be prepared to meet the rising demand for service. Occupational therapists, and other "allied health" professionals need Federal assistance for their efforts to rectify these current and future shortages. The new manpower legislation now being developed must demonstrate the government's committment in this area.

Legislative Recommendations

Although the Federal government cannot be expected to assume full responsibility for the education of health professionals, it can be expected to provide assistance to a degree proportionate to the contributions made by these professionals in carrying out Federal policies directed towards ensuring prope. health care of the nation's citizens. The Federal government has established a wide variety of programs which are intended to make necessary health care services available. Some of these programs, such as those established under the Rehabilitation Act, the Older Americans Act, the Maternal and Child Health and Crippled Childrens' Services Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act establish mechanisms through which direct services can be provided. Other initiatives, such as that found in the Education of All Handicapped Children Act, mandate that states ensure that specific services are provided to specific populations. While still others, such as Medicare, offer a health insurance program directed primarily towards assisting older Americans in the payment of health care costs. All of these Federal initiatives directly create requirements for, or expectations of, the provision of health care services.

In light of these national initiatives, it would be irresponsible for the Federal government to reduce its committment to the education of the health professionals needed to provide the services covered under these programs. Enactment of the Education of All Handicapped Children Act, for example, represented a significant and praiseworthy step towards equalizing the nation's treatment of handicapped children. This Act requires that, if a child needs occupational therapy or physical therapy in order to benefit from a special education program, this therapy must be provided. The legal right to the service, however, is of questionable value, if no therapist is available to provide treatment. The Federal government must not just mandate services, it must also provide support to ensure that qualified people are available to serve.

Federal government support for the education of health professionals, moreover, must also be more equally distributed among the various professions than it has been in the past. It has been reported by the National Commission of Allied Health Education that $4.2 billion was appropriated by the Federal government for health professionals education between 1965 and 1976. Only $183 million, or 4 percent, of this amount was allocated to "allied health" education. Yet the "allied health" professions, as estimated most conservatively by DHEW, constitute over 20 percent of the entire health care workforce. Federal support for "allied health" education has consistently failed to match the contributions made by these professionals to the health care of the American people.

At a time when rising health care costs are a major concern, Congress might also well consider the cost-effective aspects of increased support for "allied health" professionals. These professionals regularly provide services which reduce or eliminate the need for costly institutional care. The timely provision of their services hastens patient recovery and reduces the potential for recurring disability. "Allied health" care frequently enables individuals to return more quickly to revenue-producing employment. The professionals providing these cost-saving services, moreover, are not high income wage earners. The average annual salary of an occupational therapist, for example, is approximatley $15,000. Support for "allied health" could hardly be classified as an unnecessary government subsidy of wealthy professionals, while at the same time it could very accurately be described as a most effective cost containment measure.

In light of these considerations, the American Occupational Therapy Association urges a strong Federal committment to "allied health" education and offers the following recommendations relative to the legislation now being developed:

- include provisions as now contained in Sections 796, 797 and 798 of the Public Health Service Act;
- increase authorizations in existing Section 797 to $10,000,000 for Fiscal Year 1981 with increases of 20 percent per year for each successive year;
- increase authorizations in existing Section 798 to $5,000,000 for Fiscal Year 1981 with increases of 20 percent per year for each successive year;
- incorporate into the appropriate sections (for example, Section 708 of the current law if retained) provisions requiring establishment of programs to collect data on the outcome of treatment by "allied health" professionals and the impact on the total cost of health care delivery;
- incorporate into appropriate sections (for example, current Section 708) provisions requiring establishment of programs to investigate the need for capital support of "allied health" educational and training facilities with the stipulation that an authorization of $25,000,000 be set aside for appropriation

should the determination be made, prior to expiration of the legislation now being developed, that such need exists;

- establish a new section to provide institutional grant and individual loan assistance covering educational expenses of "allied health" students at the basic educational level, with emphasis noted that funds should be allocated with priority to those professions where demonstrated shortages are greatest, and establish authorizations of $20,000,000 for Fiscal Year 1981 and 20 percent per year increase in each successive year;
- establish a new section which would provide incentive scholarships for preparing faculty for "allied health" schools and include specific "pay-back" provisions requiring 2 to 4 years of teaching in designated schools where faculty shortages exist; and establish an authorization of $10,000,000 for Fiscal Year 1981, $12,500,000 for Fiscal Year 1982, and $16,000,000 for Fiscal Year 1983.

The American Occupational Therapy Association fully supports the Subcommittee's efforts to develop effective and efficient legislation regarding the education of health care personnel. The Association understands the importance of this legislation, not just for health practitioners but also for the people in need of their services. The well-being of the total health care system depends largely on the scope of the Federal government's committment to the education of health care personnel. The Association urges that, in defining the scope and degree of this committment, Congress give careful consideration to the integral and substantive roles played by the "allied health" professions and that accordingly it provide adequate support for their educational systems.

The American Occupational Therapy Association sincerely appreciates the opportunity to offer these comments.

STATEMENT OF THE

AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

BEFORE THE

SUBCOMMITTEE ON HEALTH AND
SCIENTIFIC RESEARCH

OF THE

UNITED STATES SENATE

ON

S. 2144 AND S. 2375

American Society for Medical Technology
1725 DeSales Street, N. W.
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April, 1980

STATEMENT OF THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY ON S. 2144 and S. 2375 PRESENTED TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH OF THE UNITED STATES SENATE

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Glenda Price, President of the American Society for Medical Technology. We are pleased to offer our views on proposed legislation which would revise and extend existing Federal legislation with respect to the training of health professions personnel, particularly as that legislation impacts upon the nearly 250,000 people in the clinical laboratory field.

The American Society for Medical Technology (ASMT) is the largest national laboratory professional organization working to represent health professionals who are engaged in the delivery of clinical laboratory services. The membership represents a diversity of specialists and generalists within the clinical laboratory sciences. It includes clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants and such specialists as microbiologists, clinical chemists, hematologists, immunohematologists, cytotechnologists, histotechnologists and nuclear medicine technologists.

Mr. Chairman, in 1976, clinical laboratory personnel performed nearly 5 billion tests per year at a cost of more than $12 billion or about 10 percent of the yearly expenditure for medical care. Current estimates suggest that in excess of $20 billion will be spent for laboratory services during fiscal year 1982.

Our members are highly skilled laboratory scientists who perform or supervise clinical laboratory tests and assume responsibility and accountability for precise and accurate results. We perform complex analyses which require the exercise of independent judgment, correlate test results and interpret test findings with respect to disease or normality. Our knowledge of physiological conditions affecting test results affords us the skill to produce reliable and valid results that may be confirmed by statistical measurements of precision and accuracy. As generalists and specialists, we work in a wide range of governmental and non-governmental laboratories. Approximately 85 percent of ASMT's membership currently holds an academic degree.

THE CRITICAL ROLE OF FORMAL EDUCATION IN THE CLINICAL LABORATORY PROFESSION

Mr. Chairman, the educational level of clinical laboratory personnel now ranges from graduate education with specialized training to on-the-job apprenticeships. Generally, the entry level for a clinical laboratory scientist is a baccalaureate degree with one year of clinical internship in an accredited program.

Mr. Chairman, formal education is critical to our profession, and to quality patient care. While on-the-job training provides some skills within the laboratory, it is no substitute for formal training. This fact recently was demonstrated through a study conducted by the Professional Examination Service (PES) under contract with HEW (Contract No. HRA-231-77-0118). Among the PES findings was the conclusion that, in general, academically prepared medical laboratory personnel perform significantly better than job-trained personnel on written and practical examinations. The findings of this study reaffirm our strong belief that there is a critical need for greater utilization of formally educated professionals in the laboratory. In simple terms, Mr. Chairman, in our profession, an adequate level of formal education means greater accuracy, better patient care and, thus, reduced costs of health care.

Thus, Mr. Chairman, the role of the Federal government in encouraging and stimulating formal education of the clinical laboratory scientist is of critical concern to the American Society for Medical Technology, because it is a necessary component of better patient care.

INNOVATIONS IN EDUCATION OF THE CLINICAL LABORATORY PRACTITIONER

Mr. Chairman, within our profession, formal education cannot be limited to affording future practitioners technical expertise. Our training programs must be designed to support upward mobility and prepare our practitioners for greatly expanding roles as clinical laboratory scientists.

Mr. Chairman, our profession is comprised of laboratory assistants, technicians, technologists, specialists, supervisors, directors and administrators. We support the "career-ladder" concept of vertical mobility. However, we believe in a progressive approach, made possible by a method that includes a combination of academic or formal training, well-integrated clinical training, job experience and competency based evaluation. ASMT supports educational programs geared to this concept.

Moreover, the roles of clinical laboratory scientists have greatly expanded in the laboratories over the past few years. Lateral mobility has been demonstrated in the field by science-based professionals moving into administrative, supervisory and educational positions. This has not only increased the scope, depth and quality of laboratory services provided but has reduced the need for physician services in these areas. In addition, well-trained laboratory professionals with their core curriculum in the biological, chemical, medical and (increasingly) computer sciences have great potential in filling current needs in disease prevention and environmental health programs, such as EPA toxic substance testing programs. Thus, clinical laboratory educators have a tremendous contribution to make in structuring curriculum to provide an integrated clinical and didactic education that insures the flexibility of lateral movement within the profession. These educators can make major contributions as they instruct clinical laboratory scientists in management practices that include cost containment, inter-disciplinary health care teams, health planning and efficient use of resources. Moreover, they can and must make major strides in teaching new technologies to the laboratory professional.

INFORMATIONAL STATE OF THE ART IN ALLIED HEALTH

Mr. Chairman, we have read and are in agreement with the nine recommendations contained in the statement of the American Society of Allied Health Professions submitted to this subcommittee on March 12, 1980. That statement presents, among other things, an excellent synthesis of much of the data to date that have been compiled with respect to manpower training and needs in the allied health professions. In ASAHP's statement, the report of the Health Resources Administration's Bureau of Health Manpower entitled "A Report on Allied Health Personnel" is described; so is the report on the National Commission on Allied Health Education, which followed a two-year study of allied health manpower needs. We believe that the content of these reports should be considered by your Subcommittee prior to final deliberations on the proposed legislation before you.

Mr. Chairman, we wish to call your attention to a third effort to gather information and identify problems in connection with allied health manpower. On September 11-13, 1979, the Bureau of Health Manpower convened a workshop on allied health manpower, attended by Bureau Staff and representatives of 14 allied health professional associations. The principal objectives of the workshop were to provide an exchange of information on the current availability of manpower data. to familiarize participants with available data processes, and to identify problems, issues and deficiencies in data collection and analysis and to develop a more efficient and effective means of obtaining and analyzing data on allied health manpower.

The group selected 29 critical problems within the allied health field deserving special concern and attention. We believe five of these concerns are especially crucial to the clinical laboratory profession. They are as follows:

(1) there is critical need to give more attention to the problems of turnover and lack of retention of health manpower in the clinical laboratory field;

(2) there is a need for accurate measurement of the demand for allied health services;

(3) criteria to determine need for the services of the allied health profession must be established;

(4) there is a considerable lack of information on minorities and women within the allied health professions, including the lack of data on the actual employment of minorities;

(5) there is likewise a lack of information on upward mobility of allied health workers.

Mr. Chairman, our analysis of these three reports and proceedings leads to the inescapable conclusion that, despite efforts to date, there are insufficient data on supply, demand and needs within our profession to enable proper planning of educational programs and opportunities. For this reason, we believe that continuing efforts must be made to insure that substantial resources are devoted to the collection and analysis of data in the field of allied health in general and within our profession in particular.

EXISTING FEDERAL SUPPORT OF ALLIED HEALTH TRAINING

Mr. Chairman, the clinical laboratory scientist is a professional within that broad, nebulous field called allied health. As is unfortunately sometimes the case in the health field generally, Federal legislation has relegated the allied health field to secondary status in the health manpower training budget. Despite the substantial contribution that medical technology and other professions within the allied health field make within the total health picture, the Federal support that would allow stability and innovation within our educational programs simply has not been forthcoming. In fact, although allied health personnel constitute over 60 percent of health practitioners, Federal funding under the allied health training legislation constitutes a mere 4 percent of the total Federal contributions to health manpower education.

Perhaps, Mr. Chairman, this is because of the artificial role ascribed to allied health within the law itself. Buried in the statute behind the other health manpower professions, little attention is afforded to manpower needs, manpower distribution, loans and scholarships or institutional support for the allied health field. Instead, allied health seems to be regarded almost as an afterthought -- a profession too large and important to be abandoned altogether by the Federal government, but one which is somehow not deserving of the substantial consideration afforded to the other health professions.

Let me cite a few examples.

Mr. Chairman, under existing law, there is no institutional support for programs which train "allied health personnel." Unlike schools of medicine, osteopathy, dentistry, veterinary medicine, and others, our schools are simply ineligible for Federal support to help us meet the day-to-day operations of our educational programs. Despite the findings of the Bureau of Health Manpower that there are significant national shortages within the allied health professions, there is no encouragement in the Federal legislation for the maintenance and expansion of present programs or the establishment of new programs.

Moreover, Mr. Chairman, allied health personnel are presently excluded from the loan and scholarship programs of the health manpower law. While Basic Educational Opportunity

Grants are available to our students, funding of these grants is insufficient to meet our student needs. Moreover, funding of the BEOG program faces drastic reductions in the President's budget. Lack of adequate student support is one of the principal reasons why entry into our profession from persons on the lower socioeconomic scale has been retarded. We simply must have the opportunity to compete for loan and scholarship assistance alongside other members of the health professions if we are to do appropriate jobs of recruiting the financially needy and recruiting and retaining minority students.

Mr. Chairman, our less-than-equal role in the Federal health manpower arena is exemplified in the National Health Service Corps program. Nowhere are clinical laboratory practitioners -- or even allied health practitioners, for that matter -- mentioned as eligible to receive National Health Service Corps scholarships. We strongly believe in the goals of the National Health Service Corps Program to help overcome serious geographic shortages of health practitioners. We stand ready to help in all reasonable ways to contribute to solutions to geographic maldistribution problems. We believe, however, that we must be accepted as equal partners in programs designed to achieve these goals.

COMMENTS ON S. 2375 AND S. 2144

Frankly, Mr. Chairman, we are disappointed at the continued relegation of our profession to the back burner by

S. 2375. As we read it, S. 2375 would (1) continue, with minor substantive revision, the authority for the Secretary of Health and Human Services to award special project grants and contracts, but at reduced authorization levels; (2) repeal the existing authority for advanced training of allied health personnel; and (3) repeal the special authority for assistance to persons of disadvantaged socioeconomic backgrounds to undertake education to enter the allied health professions.

S. 2144 would likewise repeal the special section for the training in allied health of persons from disadvantaged backgrounds (but make schools of allied health eligible for grants and contracts under a general provision for educational assistance of such persons in the health professions) as well as combine and continue, with revisions, the authority for special projects and advanced traineeships. It includes new authority for grants and contracts for schools of allied health (as well as other health professions schools) for projects to teach health policy and health care economics, and for curriculum improvement in these subjects, as well as for the costs of assessing and improving continued competency of health professions personnel, with emphasis on continuing education.

Mr. Chairman, we prefer the provisions of S. 2144 over those of S. 2375. In particular, we are gratified by the Schweiker proposals to continue the allied health traineeship authority and to foster and innovate special projects for curriculum improvement and continued competence. In addition, we offer the following suggestions for what we regard as the improvement of both bills.

ASMT SUGGESTIONS FOR FEDERAL LEGISLATION

Our first suggestion, Mr. Chairman, is that the Federal law's definition of the term "allied health personnel" is inaccurate and, we believe, demeaning to our profession. Specifically, we offer two suggestions for revisions in existing Section 795(1) of the Public Health Service Act:

(1) The definition refers to allied health "personnel" while physicians, dentists and unidentified others are "professionals." Senator Kennedy's legislation would end this artificial distinction by referring to all health-care practitioners affected by Title VII as "personnel," although we prefer use of the term "professionals" throughout.

(2) The definition implies that allied health professionals work for or under the supervision of physicians, dentists and environmental engineers in all instances. Obviously, this simply is not the case.

Second, Mr. Chairman, we are at a loss to understand why until only recently 60 percent of this nation's health professionals have not been represented on the National Advisory Council on Health Professions Education. We applaud, therefore, the provisions of both the Kennedy and Schweiker proposals that mandate representation on the Council of at least one representative from an allied health training center. We also support the intent behind the change in the name of the Council to the National Council on Health Professions and Allied Health Education, as proposed by S. 2144, although we wonder if the title does not unintentionally perpetuate an artificial distinction between allied health and health "professions."

Third, Mr. Chairman, Congress can demonstrate its commitment to our proposed partnership between our profession and the National Health Service Corps by making clinical laboratory practitioners eligible for participation in the National Health Service Corps Scholarship program and by accepting us as members of the Corps ready for assignment to underserved areas.

Fourth, Mr. Chairman, we strongly believe that new health manpower legislation should include a special project section with authorization for the appropriate funding and establishment of three distinct programs. The first would lead to new, expanded roles for clinical laboratory scientists. It would have three aspects. First, it would support the preparation of master laboratory clinicians. This program, which should give emphasis to the study of advanced clinical theories and methods, as well as methods of clinical laboratory research, can do much to demonstrate that expanded roles for allied health practitioners can be more cost effective than is currently the case. In the clinical laboratory field, this concept has been recommended by the National Certifying Agency for Medical Laboratory Personnel. Second, medical technologists would receive advanced training in administration and management, and, in effect, graduate to the status of laboratory administrator, fully qualified to manage clinical laboratories. The third aspect of our recommended special project for expanded roles of our professionals would provide support for teacher training to prepare laboratory practitioners to become educators. Previous professional education must be supplemented with additional training in educational skills and methods in order to better insure the development of effective classroom educators.

The second type of special project would foster curriculum development within our training institutions. This special project grant should have at least three components: First, it would support expanded training of our students in the understanding of our health care delivery system, in the behavioral and humanistic aspects of patient care, in health promotion and disease prevention, and in various approaches to cost containment and interdisciplinary education. This type of training will create better informed practitioners who are more sensitive to the needs of patients, the roles of other health professionals and the workings of the health care delivery system. Second, career progression through the "career ladder" concept would be encouraged. By better combining academic and clinical training, as well as job experience and evaluation of competency, our training institutions can do much to insure the upward mobility of the clinical laboratory professional. Finally, projects to improve curriculum development would be used to more effectively integrate clinical and didactic education. By better combining the theory of the classroom and the skills of the health care institution, our laboratory professionals will be better trained to insure effective health care.

The third type of special project grant would support continuing education and retraining programs. As is the case with most health professions, ours is a changing profession. Today's skills may be obsolete tomorrow. We are committed to the concept of continuing education and believe that our formal training programs are well suited to providing instruction in new findings and technology to clinical laboratory practitioners.

Finally, Mr. Chairman, because of our concern over lack of data with respect to our profession, we recommend that a National Census on Clinical Laboratory Personnel be mandated. The latest census, conducted by the Center for Disease Control in 1971, is badly outdated. We believe that the problems surrounding lack of data on supply, demand and need within our profession can largely be overcome through a new census.

Mr. Chairman, we recognize that provisions of Senator Schweiker's proposal for special projects to all health professionals schools would authorize support of these three programs. We believe, however, that the projects we have described are so critical to our profession - and offer such great potential - that they are deserving of special legislative attention.

Mr. Chairman, this concludes our prepared testimony. We stand ready to assist the Subcommittee and its staff in assuring attainment of our mutual goal of better health care for all Americans.

Respectfully submitted,

/S/ Glenda D. Price

Glenda D. Price, Ph. D.
President
American Society for
Medical Technology

1930-1980
UNIVERSITY OF WISCONSIN-MADISON THE SCHOOL OF EDUCATION
50 YEARS

Department of Studies in Behavioral Disabilities
1500 Highland Avenue
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STATEMENT OF BRUCE B. BLASCH, Ph.D., MOBILITY TRAINING PROJECT, DEPARTMENT OF BEHAVIORAL DISABILITIES, WAISMAN CENTER, UNIVERSITY OF WISCONSIN TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH COMMITTEE ON LABOR AND HUMAN RESOURCES, U.S. SENATE ON PENDING HEALTH PROFESSIONS TRAINING AND DISTRIBUTION ACT OF 1980.

Mr. Chairperson and members of the subcommittee, I appreciate the opportunity to present the views of two national organizations regarding the need for legislation to train allied health personnel.

The organizations I represent are the Orientation and Mobility Specialists of the american association of workers for the Blind, a national membership organization of mobility therapist serving blind persons; and The Association of University Educators in Orientation and Mobility and Rehabilitation Teaching for Visually Impaired Persons, an organization of faculty from university training programs graduating mobility therapists and rehabilitation teachers.

In keeping with the intent of S2144, both of these organizations are particularly interested in the training of allied health professionals. I would therefore like to direct this brief statement to Section 795 of S2375 and to Sec. 746 of S2144. Mobility therapy for visually impaired individuals involves the art and science of presenting those aids, methods, services and skills which enable the individual to move from one place in the environment to another with confidence, safety and purpose. This definition of mobility goes beyond the idea of ambulation and articulation of the body parts in a clinical setting. In doing so, it incorporates the intellectual, (orientation, problem solving, etc.), psychosocial (self-concept, stigmatization, etc.) and motor factors of an individual travelling independently and interacting in the real environment.

This concept of mobility therapy was developed by the Veterans Administration following World War II at Hines Veterans Hospital, Hines, Illinois. Since that time, mobility therapy has been regarded as probably the most significant service provided to all ages of visually impaired individuals.

The magnitude and success of this therapy is exemplified by the fact that other countries have adopted identically the mobility therapy. Such countries as Norway, Australia, S. Africa, Brazil, Japan, West Germany, the United Kingdom and most recently Poland, to mention a few, have either sent people to be trained in the United States or have brought American mobility therapists to their country to establish programs. From 1966 to 196[illegible] a mobility therapist under the sponsorship of the World Rehabilitation Fund, initiated and directed a program for blind persons in South Vietnam. This science ofmobility therapy has continued to keep the United States as the model for other countries to evaluate and look to for leadership and innovations.

Mobility therapists in the United States began to realize that many of the problems of independent travel without vision were not the obvious difficulties expected. Much of the therapy time was spent on more subtle problems that only became apparent as the mobility therapist and visually impaired person became involved in the total process of learning to travel independently. It was this realization that prompted experimental programs which apply this form of mobility therapy to persons with disabilities other than visual impairment as well as to multiply impaired individuals.

Some of the factors that were found to limit a disabled person's (i.e. geriatric, cerebral palsied, mentally retarded, mentally ill, stroke, spinal cord injured, etc.) independent mobility include the following: (1) the lack of travel experience, which in itself can be a strong deterrant to independent travel, (2) the effects of overprotection and experiential deprivation, including insufficient knowledge about and understanding of the environment, (3) fear and anxiety related to travelling alone, (4) lack of confidence in one's travel and orientation abilities, (5) communication problems, (6) difficulties with problem solving and decision making, (7) lack of endurance and stamina related to age, medical problems, or insufficient opportunities to develop the necessary endurance, (8) stigmatizing or embarrassing aspects of visible disabilities or atypical behaviors, (9) the reactions of others on the street, and (10) the fears and expectations of family members.

Based on the knowledge of the universality of these factors limiting mobility, mobility therapists applied this training to clients with a variety of disabilities. The success of this therapy was realized when handicapped individuals for the first time were able to use public transportation independently and take advantage of the recent changes in enviromental accessibility.

The significant implications of this mobility therapy are in support of and indeed may be the keystone to several major national programs. First, with the trend away from institutionalization and toward mainstreaming, it is important that comprehensive training be available to allow any handicapped individual to obtain his/her optimum level of independence. The ability to negotiate within the environment is essential to participate in all activities of daily living. This fact has been recognized in recent legislation pertaining to handicapped individuals. The Education for All Handicapped Children

Law (P.L. 94-142) guarantees all children the right to a free public education and encourages the integration of handicapped children into existing programs. In doing so, this law states that all programs must be physically accessible to the student. In addition, this law mandates that mobility therapy be available to all visually impaired students. The Rehabilitation Act of 1973 mandates that all educational, rehabilitation and social programs receiving federal funds be accessible in order that handicapped people be able to participate in such programs. Other laws address the accessibility of the man-made environment. Specific building standards (ANSI) have been developed, all federally owned or funded buildings must be accessible, and both tax incentives and government loans have been made available to the private sector when it builds in accordance with the ANSI standards. Also, municipal transportation systems receiving federal dollars must provide service to the handicapped population. Although the government and the private sector have invested considerable efforts in time and money in order to improve environmental conditions, handicapped people are not travelling and making use of the modifications and transportation services now available to them (Newsweek, 1/15/79). As a consequence of this lack of use by handicapped individuals, many individuals are reconsidering the necessity for making these changes in the environment. This unfortunate backlash phenomenon is occurring because many handicapped individuals do not have the mobility skills and confidence necessary to travel independently. The subtle factors mentioned above, that can limit a person's mobility, have not been considered. Based on recent research, mobility therapy provides this vital training for many handicapped individuals, thus enabling them to take advantage of the significant strides made in environmental accessibility.

The second implication relates to the energy shortage and to the emphasis in maximizing use of public transportation. For many agencies, institutions, cities and programs for elderly and handicapped persons, maintaining a specialized transportation system has become an enormous financial burden. Mounting transportation costs continue to cut back and to eventually eliminate funding for other programs and services needed by the elderly and handicapped. One aspect of mobility therapy mentioned above was the individualized instruction in the independent use of public transportation. One program documented that by having a mobility therapist on staff for one year (in 1974) it saved approximately $50,000 in transportation costs. Another program states that for every dollar spent in mobility therapy, $9.00 are saved in transportation costs. These savings are attributed to the handicapped individuals using public transportation and no longer needing costly specialized transportation. This also facilitates mainstreaming and energy conservation.

CONCLUSION

While mobility therapy is available for visually impaired individuals the magnitude of its value for individuals with other handicaps has only recently been demonstrated. We would, therefore, urge the Committee to include in its report, accompanying legislation to extend allied health manpower programs, specific intent language directing the Secretary to extend current mobility training programs and to provide short term training programs for practicing mobility therapists. This recommendation is particularly significant to Section 746 of S2144.

Thank you for your attention and consideration of this testimonial.

NATIONAL ASSOCIATION of HEALTH CAREER SCHOOLS

Please reply to office indicated:
☐ WASHINGTON OFFICE 1919 PENNSYLVANIA AVENUE, SUITE 800 · WASHINGTON, DC 20006 · (202) 785-5237
☒ ADMINISTRATIVE OFFICE 11687 BELLAGIO ROAD, SUITE 16 LOS ANGELES, CALIFORNIA 90049 (213) 472-1806

March 14, 1980

Senator Edward M. Kennedy, Chairman
Senate Health Subcommittee
Room 308C Senate Courts Building
Washington, DC 20510

Dear Senator Kennedy: Re: Health Manpower Legislation

On behalf of our 177 member institutions, we are pleased to offer our support of the position presented to your Subcommittee by Dr. Lee Holder on behalf of the American Society of Allied Health Professions.

In particular, we direct your attention to pages 18-19 of Dr. Holder's remarks of March 12 concerning data collection. While our member institutions and similar allied health programs across the nation train many thousands of allied health workers in a wide range of occupations, the fact that these are not in college settings has prevented the Bureau of Health Manpower from collecting data on these graduates. The result is a serious gap in information, information necessary to assure that the nation's allied health personnel demands are met.

Specifically, the biennial survey of allied health programs conducted by the Bureau of Health Manpower fails to deal with "certificate" programs in our schools. It is estimated that the cost of expanding the survey to this universe would cost less than $5,000 and would generate much valuable data. Changing the language in proposed Section 708 of S. 2144 would accomplish this.

The "ripple effect" of expanding the data base is significant. For example, I have worked here in California with the state postsecondary education commission in preparing our health manpower education plan. BHM data is utilized by the commission staff to track college-based programs, but little date is available on certificate programs. Many of these are duplicates of college courses, enjoying the same accreditation, certification, etc., yet their graduates are "lost." If we had BHM data, our task and that of similar bodies in other states would be greatly enhanced.

We urge this amendment and hope that this letter can appear in the permanent record of your proceedings.

Very truly yours,

Jay [illegible]. [illegible]ulins

cc: Tom Jolly, O'Connor & Hannan

ICA
INTERNATIONAL CHIROPRACTORS ASSOCIATION
EXECUTIVE OFFICES

March 25, 1980

Robert Knous, M.D.
Subcommittee on Health
and Scientific Research
Senate Committee on Labor
and Human Resources
Washington, D.C. 20036

Dear Dr. Knous:

Here are five copies of our testimony concerning the reauthorization on health manpower legislation. I request that this testimony be made part of the record.

Sincerely,

Christopher Luis

Christopher Luis,
Staff Counsel

enclosures

CL/kmb

1901 L STREET, N.W., SUITE 800, WASHINGTON, D.C. 20036 TELEPHONE (202) 659-6476

ICA
INTERNATIONAL CHIROPRACTORS ASSOCIATION
EXECUTIVE OFFICES

TESTIMONY OF THE
INTERNATIONAL CHIROPRACTORS ASSOCIATION
ON
HEARINGS FOR THE RENEWAL OF HEALTH MANPOWER LEGISLATION

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
SENATE COMMITTEE ON HUMAN RESOURCES

MARCH 10, 1980

1901 L STREET, N.W., SUITE 800, WASHINGTON, D.C. 20036 TELEPHONE (202) 659-6476

INTRODUCTION

The International Chiropractors Association is pleased to present testimony on the renewal of health manpower legislation.

As the Subcommittee members are aware, Section 903 of the Health Profession Educational Assistance Act of 1976 provided that a study concerning the chiropractic profession be performed. This represents the first federally funded study ever done on the chiropractic profession. Specifically, the report covers the cost of education, the demand for services, the supply of chiropractors and, the types and cost of services provided by chiropractors. It is our understanding that the Department of Health, Education and Welfare will soon provide the Committee with this report.

In this statement, we are submitting additional information concerning the chiropractic profession which may be helpful to the Subcommittee. We also address the need for federal funding under health manpower programs to chiropractic students and colleges.

PART I

BACKGROUND INFORMATION ON CHIROPRACTIC

Chiropractic is the second largest primary health care service in the United States. In their order of size, and based on the number of practitioners and public utilization, the three largest branches of the healing arts are allopathic care or medicine, chiropractic and osteopathy.

All fifty states plus the District of Columbia, Puerto Rico and the Virgin Islands license and officially recognize chiropractic as a health profession. All fifty states authorize chiropractic services as part of their workmen's compenstaion program. Virtually all major commerical health and accident policies provide for chiropractic services. Major industrial unions, such as General Motors, have included chiropractic in health plans for employees and their dependents. In addition, substantial numbers of major international, and national and local unions include chiropractic in their health and welfare plans.

Chiropractic services are recognized and authorized by the federal government under Medicare, Medicaid, vocational rehabilitation programs, and the Internal Revenue Code (as a medical deduction). In addition, legislation to amend and improve current coverage of chiropractic services under Medicare has recently been the subject of favorable committee action by both the House and Senate. This measure also shares broad bipartisan support from Congress.

Sepcifically for federal employees, chiropractic services are provided under:

(1) federal employee health programs;

(2) in federal employee workmen's compensation; and,

(3) in leave approvals for civil service excuse of illness.

Federal funding of chiropractic has been provided under appropriation measures sent to the Department of Health, Education and Welfare (see page 4) and, for the statistical survey of the chiropractic profession under the last health manpower act.

The United States Office of Education officially recognizes the Council on Chiropractic Education (CCE) as an accrediting agency for chiropractic educational institutions. This autonomous national organization oversees the quality of education at the chiropractic institutions. Within the CCE is the Commission on Accreditation, which is responsible for the accredition process. This group is composed of members representing the state licensing boards, the member institutions, sponsoring national associations and non-chiropractic members representing the general public.

Currently, there are about 23,00 Doctors of Chiropractic providing chiropractic services to the public on a full-- or part--time basis. Within the next five years between 10,000 and 13,000 new Doctors of Chiropractic (D.C. s) will enter the labor force. Therefore, within the next five years the number of chiropractors practicing in this country will increase some 40 percent.

The national ratio of chiropractors to the population is 10.1 per 100,000. However, these chiropractors are not evenly distributed across the United States. The variation from state to state is significant, ranging from 1.8 per 100,000 in Virginia to 23.0 per 100,000 Iowa, and 25 percent of chiropractors are practicing in just five states.

The chiropractic profession, however, deploys most of its manpower to the nation's smallest and often most neediest communities

Slightly more than 40 percent of the D.C.'s practice in areas with fewer than 25,000 persons. A clear majority, or approximately 70 percent practice in areas with fewer than 100,000 persons.

The typical parcticing chriopractor is a white male, and approximately forty-five years of age. Less than 1 percent are either Black, Hispanic, American Indian or Asian. Only 3.2 percent are female. Therefore, in addition to the tremendous geographic and demographic maldistribution, the profession suffers a severe ethnic, race, and sex underrepresentation.

CONTRIBUTIONS MADE BY CHIROPRACTIC TO THE HEALTH NEEDS OF AMERICANS

It has been estimated that Doctors of Chiropractic had 122.5 million patients visits in 1979. This is based on survey data estimating that 6.8 million individuals went to a D.C. in 1979, and returned 17 more times for additional care during the year. However, this may be a conservative estimate given that 7.5 million individuals saw a D.C. in 1974 (1974 Health Interview Survey National Center for Health Statistics). Over $1.3 billion were generated in practice revenues in 1978 by D.C. s.

These figures show that practicing D.C. s exert a considerable influence on this nation's health needs. Because D.C. s offer a wide range of services, such as physical exams, spinal adjustments, certain x-rays, and routine laboratory services, they are valuable and important in the health care delivery system. Often as primary health care providers in rural or remote areas D.C.'s are relied on by many Americans for physical examination and spinal care or, referral to other health care providers.

STUDIES SHOW CHIROPRACTIC CARE EFFECTIVE

For 1978, the National Safety Council estimated that accidents and occupational illnesses alone cost the United States at least $84 billion. And, an estimated 10 million man-hours, or 10 percent of all lost-time injuries were the result of back injuries. This fact is relevant since results from several industrial back injury studies performed by independent groups, two by medical doctors, show that spinal manipulative therapy performed by chiropractors can be very effective in relieving musculo-skeletal symptoms. These studies (Appendix) indicate that cases handled by a chiropractor result in significantly less "time lost" by the injured party and, that chiropractic treatment results in lower medical expenses.

Considering the direct relation between the loss of productivity and the health and safety of the American work force, chiropractic care makes a tremendously important contribution not only to the health care needs of the industrial work force, but to the nation as a whole.

Back injuries are suffered by not only the industrial worker but by all Americans--from the housewife who lifts a heavy basket of clothes, to the office worker who turns the wrong way, to the weekend gardener mowing the lawn, or to any number of individuals in commonplace situations. Therefore the role of chiropractic in the health care delivery system is vitally important to the health needs of all Americans.

CHIROPACTIC RESEARCH

Although the profession has engaged in some research activities on its own, recent Federal funding has been a source of revenue and encouragement. As part of the Senate Report on the FY 1974 Appropriations for the National Institute of Neurological Diseases and Stroke (NINDS) of the National Institute of Health (NIH), the

Senate Appropriations Labor- HEW Subcommittee said "... this would be an opportune time for an 'independent, unbiased' study of the fundamentals of the chiropractic profession." Appropriation measures passed that year alloted some $2 million for chiropractic research.

In pursuit of that direction, the National Institute of Neurological and Communicational Disorders and Stoke, convened at the National Institute of Health a "Workshop on the Research Status of Spinal Manipulative Therapy" on February 2-4, 1975. This workshop focused directly on the evaluation of research results and clinical investigative experience. Participants included 58 scientists and clinicians of national and international stature including 16 Doctors of Chiropractic (D.C. s), 24 Doctors of Medicine (M.D. s), 7 Doctors of Osteopathic Medicine (D.O. s), and 11 basic scientists (mostly Ph.D. s). A second workshop was also held on October 23-27, 1977 at the Kellogg Center for Continuing Education, Michigan State University in East Lansing Michigan, and dealt with "Neurological Mechanisms in Manipulative Therapy." These workshops represent the beginnings of an interprofessional dialogue among chiropractors, physicians and biological scientists on the "neutral" and commonly-shared issues of science and research.

One observation of the NINDS workshop was that "specific conclusions cannot be derived from the scientific literature for or against either the efficacy of spinal manipulation therapy or the pathophysiological foundations from which it is derived. Chiropractors, osteopathic physicians and medical manipulative specialists and their patients all claim spinal manipulation provides relief from pain, particularly back pain, and sometimes cure." The report also noted that "some medical physicians, particularly those not trained in manipulative techniques, claim it does not provide relief, does not cure, and may be dangerous, particularly if used by non-physicians. The available data does not clarify either view " (our emphasis).

The report concludes that the "efficacy of spinal manipulative therapy is based on a body of clinical experience in the 'hands' of specialized clinicians." But, that there is little scientific data of significance from which to evaluate this clinical approach to health. The workshop suggested the promotion of fundamental and clinical research so that "answers to the questions of clinical indications and therapeutic efficacy of manipulative therapy can be approached more meaningfully." And, it did point out that "established and prestigious medical and osteopathic physicians and chiropractors provided testimonial evidence in support of the efficacy and safety of manipulative therapy.

Since 1969, basic research on the biomechanics of the spine has been conducted by Chung Ha Suh, Ph.D. at the University of Colorado. The goal of Dr. Suh's research is to learn precisely what happens - biomechanically, physically, neurologically, and chemically - when a spinal adjustment is made. One of the results of this research was the development of the first three dimensional computer model of the spine. By transfering mathematical equations relating to the spine and its articulations, into the computer, a "graphics model" has been refined to the point where it is possible to see a spine in motion when the mathematical equivalent of various physical forces are programmed into the computer. One of the goals of the project is to give practicing chiropractors the means to see exactly how a patient will be affected by an adjustment before the chiropractor actually performs it. It will help practicing chiropractors detect a subluxation more precisely and remove them more efficiently.

This program has been funded by our association and by a $238,000 grant from NHI and an application for additional funds is now pending before the National Institute of Neurological and Communicative Disorder and Stroke.

Incidentally, members of the automobile industry have purchased this three dimensional computer model of the spine for the possibility of performing less costly as well as more precise information gathering tests in automobile safety crash simulation. This is but one the many benefits which basic fundamental research can provide to the scientific community.

Continued federal interest in basic chiropractic research can be seen in Senate Appropriations Report, #96-247 to accompany H.R. 4389, a bill making appropriations to the Department of Labor and the Department of Health, Education and Welfare for the fiscal year ending on September 30, 1980. The Committee report encouraged HEW "to continue research on chiropractic services, especially the biomechanics of the spine, to scientifically evaluate the chiropractic adjustment."

As a complement to these programs and as an example of our continued interest in and support for research, ICA this year established the Institute for Chiropractic Research (ICR). The purpose of ICR is to train chiropractors to conduct clinical research in a accordance with established scientific methodology. The course will set out to train the chiropractor in proper scientific methodology, mathematics for computer, computer-aided x-rays analysis, biomechanics and writing research grant proposals. Chiropractic research is at the point of what can be described as "the tip of the iceberg." With further research, contributions which chiropratic can made to the health of Americans will only increase.

RECENT REPORT ON CHIROPRACTIC

We would be negligent if we did not bring to the Committee's attention a report commissioned by the New Zealand Government entitled, "Chiropractic in New Zealand: Report of the Commission of Inquiry". This report represents the most definitive investigation and evaluation of chiropractic in its 85 year history. looks at the profession worldwide.

For your convenience we provide a short summary and analysis of the report as it appeared in one of our publications.

> "For decades the chiropractic profession has been battling the label "unscientific cult." Now, with the overwhelming assistance of the New Zealand government, chiropractic has solid documented evidence that "modern chiropractic is a soundly-based and valuable branch of health care in a specialized area neglected by the medical profession . . . worthy of public confidence and support."

So concludes a study conducted by the New Zealand Commission of Inquiry, originally set up to determine if chiropractic services should be covered under New Zealand health and accident compensation benefits. The study, completed October 5, 1979, is guaranteed to revolutionize the status of chiropractic worldwide. What was originally thought to be a "relatively simple inquiry . . . lasting no longer than a month or two" became a nearly two-year investigation which is "the most comprehensive and detailed independent examination of chiropractic ever undertaken in any country."

Realizing the "need for solid facts and concrete evidence," in light of chiropractic's controversial history, the commission decided to conduct the inquiry through public hearings. None of the members of the commission - a scientist, chemistry professor, headmistress, and their legal counsel - had had any previous experience with chiropractic treatment. In their own words, "We had no clear idea of what might emerge . . . If we had any general impression of chiropractic it was probably that shared by many in the community: that chiropractic was an unscientific cult, not to be compared with orthodox medical or paramedical services."

After compiling 377 pages of testimony, factual evidence, and recommendations on every aspect of chiropractic worldwide, the commission concluded that their preconception of the profession was totally incorrect.

Though the original purpose of the inquiry was confined to chiropractic in New Zealand, members of the commission focused a great deal of attention on the profession in North America. Since many New Zealand chiropractors are educated outside New Zealand, the commission felt it was necessary to broaden their investigations to include Austrailia, the United Kingdom, Canada, and the United States.

The final report of the Commission is divided into six parts: 1) Introductory (to the proceedings) 2) The Essence of Chiropractic 3) Evidence Against Chiropractic 4) The Evidence in Favor of Chiropractic 5) Science and Education and 6) Chiropractic and the General Health Team.

The report also covers chiropractic education, devoting a section to the history and controversy of CCE, and further investigates the medical/chiropractic animosity, recommending that, "Chiropractors should, in the public interest, be accepted as partners in the general health care team." Finally, the study concludes with an outline of recommended benefits for chiropractic treatment.

For the first time, a study commissioned and carried out by non-chiropractors has affirmed, with evidence in hand, that "modern chiropractic is not an unscientific cult." Each area of chiropractic discussed in the study has been treated fairly and comprehensively with testimony from experts and pertinent witnesses and summaries by the commission. The impartiality and breadth of this inquiry is indisputable and recommends it as the most significant and responsible documentation of chiropractic ever produced.

Following is a summary of the Commission's principal findings, reprinted from the study's introductory section:

- Modern chiropractic is far from being an "unscientific cult."

- Chiropractic is a branch of the healing arts specializing in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level.

- Chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy.

- General medical practitioners and physiotherapists have no adequate training in spinal manual therapy, though a few have acquired skill in it subsequent to graduation.

- Spinal manual therapy in the hands of a registered chiropractor is safe.

- The education and training of a registered chiropractor are sufficient to enable him to determine whether there are contra-indications to spinal manual therapy in a particular case, and whether the patient should have medical care instead of or as well as chiropractic care.

- Spinal manual therapy can be effective in relieving musculo-skeletal symptoms such as back pain, and other symptoms known to respond to such therapy, such as a migraine.

- In a limited number of cases where there are organic and/or visceral symptoms, chiropractic treatment may provide relief, but this is unpredictable, and in such cases the patient should be under concurrent medical care if that is practicable.

- Although the precise nature of the biomechanical dysfunction which chiropractors claim to treat has not yet been demonstrated scientifically, and although the precise reasons why spinal manual therapy provides relief have not yet been scientifically ex-

> plained, chiropractors have reasonable grounds based on clinical evidence for their belief that symptoms of the kind described above can respond beneficially to spinal manual therapy.
>
> - Chiropractors should, in the public interest, be accepted as partners in the general health care system. No other health professional is as well qualified by his general training to carry out a diagnosis for spinal mechanical dysfunction or to perform spinal manual therapy.
> - The responsibility for spinal manual therapy training, because of its specialized nature, should lie with the chiropractic profession. Part-time or vacation courses in spinal manual therapy for other health professionals should not be encouraged.
> - The education provided by the International College of Chiropractic at the Preston Institute in Victoria is of a high standard.
> - Bursaries should be made available to New Zealand students who wish to undertake a course leading to the B.App.Sc. (Chiropractic) degree at Preston Institute.

Again we emphasize that this is a summary of the report. We would be happy to provide full copies of this report to the Committee and its staff.

It is interesting to note that the Commission did recommend that funds be provided for chiropractic education.

CHIROPRACTIC EDUCATION

A Doctor of Chiropractic, as a member of the healing arts, is concerned with the health needs of the public. The chiropractor gives particular attention to the relationship between the spinal column and the nervous system and their role in the restoration and maintenance of health. The chiropractor is educated in the basic and clinical sciences, as well as in related health subjects. His professional education prepares the doctor of chiropractic as a primary health provider. As a portal of entry to the health delivery system, the chiropractor is well trained in diagnosis and spinal analysis, in caring for the human body in health and disease and, to consult with or refer to other health care providers when the form of treatment lies outside their specialty.

EDUCATIONAL REQUIREMENTS

The admission of students to a chiropractic institution is in the hands of an admissions officer who is a member of the Committee on Admissions of the CCE. Documentary evidence of a candidate's preliminary education is obtained directly from the undergraduate college which the candidate attended. All transcripts, and records of the candidate are kept on file at the chiropractic institution.

All candidates must furnish proof of having acquired at least two years (or 60 acceptable semester hours) leading to a baccalaureate degree in the arts and sciences, including laboratory courses in biology and chemistry.

The average length of study for students seeking a D.C. degree at a chiropractic college is three and a half calendar years (four academic years). Therefore the minimum requirements for a student to earn his D.C. degree is six academic years of training (i.e. two years of an undergraduate college and four years at a chiropractic college.) However, many in the current crop of today's chiropractic students have either a B.A. or B.S. degree and others have M.A. or M.S. before entering chiropractic college.

ACCREDITATION OF CHIROPRACTIC COLLEGES

As a national agency within the United States that accredits chiropractic colleges, the Council on Chiropractic Education is provided recognition by:

(1) The United States Office of Education's Division of Eligibility and Agency Evaluation;

(2) The Council on Postsecondary Accreditation (COPA) This is a national autonomous body that certifies anc accredits the accrediting agencies in the United States, which in turn provides the status for our colleges and universities; and,

(3) The state licensing boards of some 40 states which enhance CCE standards as the minimum that they require of applicants who seek licensure in their states.

The CCE concerns itself with the formulation of education, promotion of higher educational endeavors, and general improvement in college facilities, students and faculty. Thus, the purpose of the CCE can be briefly stated as follows:

(1) advocating high standards of quality in chiropractic

education;

(2) establishing criteria of institutional excellence for educating doctors of chiropractic and,

(3) inspecting and accrediting colleges through its Commission on Accreditation.

The Commission of Accreditation monitors the quality of education offered by the chiropractic institution. Institutions are evaluated by a highly specialized team of educational experts. Standards have been developed over the years and represent the minimum requirements an institution must meet to acquire status. These standards cover every aspect of an institution's operation and include: objectives, administration, finance, scholastic regulations, faculty, library and physical plant, research and continuing education. CCE's standards are intended as qualitative guidelines for chiropractic institutions.

Currently, seven out of the 16 U.S. chiropractic colleges are fully accredited by the CCE. An additional four institutions are "recognized candidates for accreditation." A recognized candidate for accreditation status indicates that an institution has given evidence of sound planning, has the resources to implement these plans and has an intent to work toward accreditation. Accredited status indicates compliance with all essential standards of the CCE. As such, 11 out of the 16 chiropractic colleges in the United States have status with the CCE. Four other chiropractic colleges are taking the initial necessary steps to attain status with the CCE, and are affiliated members.

CURRICULUM

The curriculum at a chiropractic college is set to provide the student with a thorough understanding of the structure and function of the human organism in health and disease. This well balanced presentation gives the student an understanding of the essential features of the life processess: digestion, excretion, physical and mental growth, nutrition, metabolism, the nervous system the significance of developmental defects, behavior and other elements which are fundamental of the understanding of pathological conditions. This understanding of structure and function makes it possible of students to identify deviations from the norm and provide the essential facts required later for diagnostic screening, chiropractic care when indicated or referral to other health care providers.

Course offerings at CCE approved colleges include the following disciplines: human anatomy, biochemistry, physiology, microbiology, pathology, public health, physical, clinical and laboratory diagnosis, gynecology, obstetrics, pediatrics, geriatirics, dermatology, psychology, dietetics, orthopedics, physical therapy, first aid and emergency procedures, spinal analysis, principles and practice of chiropractic, adjustive technique and other appropriate subjects.

CLINICAL EDUCATION FOR D.C. STUDENTS

Clinical experience is the major feature in the educational preparation of a D.C. student. Each college operates a general teaching clinic in which externs gain experience with patients in the various aspects of chiropractic practice and treatment methods.

These clinical facilities operate so that they may:

(1) provide a student with quality experience in all aspects of patient examination be it historical, roent-

genological, physical, laboratory or psychological;

(2) provide a volume and variety of cases such as to provide the externs with the experience necessary to develop and perfect the skills necessary for a D.C. to diagnose, and refer to other specialities; and,

(3) provide experience which will ensure that each extern demonstrates acceptable competency levels in clinical skills and for the development of poise and confidence in the extern.

Additionally, CCE requirements also suggest that clinics:

(1) attractively house the number of active patients appropriate to the size of the student body;

(2) provide space and teaching facilities for a clinical staff large enough to permit substantial individual exchange;

(3) maintain a clinic staff sufficient in number and credentials to insure the development of a high level of skills in the student; and,

(4) encourgae and provide programs and facilities whereby the externs and clinic staff may participate in instructionally related research.

FACULTY STUDENT RATIO

Currently, CCE requirements mandate that a faculty-student ratio of 1:15 be maintained at a CCE approved school. However, the actual ratio of full time faculty to D.C. students averages 1:13 and ranges from 1:9 to 1:24.

LICENSING OF A DOCTOR OF CHIROPRACTIC

Since the practice of chiropractic is subject to the laws of the states, responsibility for evaluating competency and qualifications of those desiring to enter chiropractic practice has been given to the licensure boards within the individual states. These licensing boards administer clinical examinations to all candidates, and also evaluate the candidate's knowledge and understanding in the art and science of chiropractic.

However, most D.C. students take a two-part exam administered by the National Board of Chiropractic Examiners. This "national Board" permits evaluation in twelve areas which the candidates must be fully competent. Candidates who have successfully demonstrated their knowledge in all subjects may be exempt from written examinations in the 48 states who recognize these examinations. A national program of this type is valuable to state licensing boards since it provides them with candidate scores based upon examinations given to graduates of all chiropractic colleges. State boards who waive their written examinations and opt for the national boards find that more attention can be given to the administration and evaluation of clinical examinations.

The first part of the exam, either national or state, tests the basic science subjects. These are the same subjects that other health professional including M.D.s and D.O.s must take. Included are: anatomy, physiology, chemistry, pathology, diagnosis, hygiene and public health. The second part of the board is a more specialized test which examines the candidates' expertise in chiropractic. Examples of subjects examined include: principles and practice of chiropractic, and spinal adjusting. neurology and orthopedics, x-ray technique and diagnosis.

Only after passing this rigid examination and only after the state board fully investigates the candidates educational and personal background can a candidate practice in the state. After this intensive training the chiropractor is fully competent and equiped to make neurological and orthopedic examinations,

to administer spinal adjustments or manipulation when required, and to identify conditions which lie outside the chiropractor's scope of care and/or contraindicate manual spinal manipulation.

SUMMARY ON EDUCATION

The requirements outlined herein, demonstrate that the education provided to a chiropractic student and the licensing requirements he or she must meet are sufficiently rigid to assure that only a highly skilled and trained specialist is allowed to practice. As was reported by the Commission of Inquiry on Chiropractic in New Zealand p. 234-235:

> While the specific chiropractic courses are not taught outside chiropractic colleges, there is much other material that is ... more than half the contact hours in the 4- to 5- year course offered are concerned with just those topics which are to be found in any standard preclinical medical course. The chiropractic student is therefore well exposed to anatomy, physiology, and diagnosis (including laboratory procedures) and in a CCE college he will probably be taught these subjects by a non-chiropractor using standard medical texts. He is therefore exposed to the whole range of scientifically based factual material as medical students are.

PART II

CHIROPRACTIC AND HEALTH MANPOWER

The geographic maldistribution of chiropractors is one issue the federal government has to address. Although the national ratio of chiropractors to the population is 10.1 per 100,000, these chiropractors are not evenly distributed across the United States. The variation ranges from a high of 23.2 per 100,000 in Iowa to a low of 0.9 per 100,000 in the District of Columbia. (see appendix) The regional distribution of chiropractors also varies significantly ranging from 6.8 per 100,000 in the New England States to 15.2 per 100,000 in the Pacific States. (see appendix) This maldistribution problem is particularly acute in the cities where less than 30% of the chiropractic profession practices.

Considering that there are no intrinsic differences across states in their "need" for chiropractic services, the large differences in density of D.C.s indicates a very large potential demand in the lower density areas. One would certainly expect that the degree to which the public is well informed about chiropractic and its availability would directly affect the level of service utilization in the area. A recent study funded in part by the federal government reported that 49 percent of a local population would utilize chiropractic services if it were available in a community health plan.

To adequately serve the health care needs of this country, the federal government should address the issue of severe geographic maldistribution and urban-rural maldistribution of chiropractors in the United States.

Added to this problem within chiropractic is the severe underrepresentation of women and minorities within the profession. Currently, less than 10 percent of chiropractic students are female and less than 1 percent are members of minority groups. Such inequities indicate that a sizeable portion of our population is not receiving needed care.

We wholeheartedly agree with the premise that health professional schools are a national resource and bear a special responsibility to help solve the health manpower problems of this nation. But to do this, the schools must be financially stable. All our chiropractic colleges are private, freestanding institutions; they are neither public institutions which have the government as a primary sponsor nor are they parts of universities on which to rely for financial support. Their financial status is often dangerously close to bankruptcy. Added to these problems are inflation, which erodes the value of each revenue dollar, and the increased and unfulfilled need for more programs and capital improvements.

The chiropractic institutions receive virtually no government support, from neither federal nor state and local sources. Indeed, the states and local communities cannot be expected to meet the needs of the colleges since these programs would have to address national goals.

Our institutions have to rely on ongoing campaigns for philanthropic support. These gifts are being used to meet the obligations for capital improvements which must be made and are merely enough to maintain the status quo and keep the colleges solvent. Little if any funds are available for special projects, improvements of facilities, continuing education, more advanced clinical training, or recruitment of women and minority students. Added to this problem is the fact that practicing Doctors of Chiropractic cannot be attracted to faculty positions since field doctors earn three times as much as faculty members within the profession.

The funding needs of our colleges are so large, and need for new programs and improvements so great, that only through federal support of institutions as provided under a health manpower program could their needs be met. Otherwise, the only other reasonable and secured source available for such substantial sums is the student tuition.

We agree that students should be responsible for a large share of their professional education, simply because Doctors of Chiropractic share with other health professionals the enviable position of earning incomes in the nation's highest bracket. However, gross inequities are obvious when you compare the percentage of operating costs covered by tuition at chiropractic institutions with that covered by tuition at other health profession's institutions. Tuition and fees currently comprise almost 70% of our colleges' operating incomes. This figure is in sharp contrast to the 9.9 percent for the eight health professional groups studied in the 1972 Institute of Medicine Report. This problem is aggravated by the fact that chiropractic students have little or no income and few loans or scholarship programs are available to them, at least not to the extent that aid is available to other health profession's students.

Therefore, we respectfully request that Federal legislation be enacted under health manpower programs to provide assistance to our educational institutions and students.

INSTITUTIONAL SUPPORT

One particular problem which faces our colleges is that some 40 states require that new practitioners be graduates of CCE approved schools. Since the CCE is a recent development, the majority of our schools are only recently attempting to attain accreditation. Often, resources are stretched to the limit in order to meet a specific CCE requirement. This channeling of funds hurts the student directly since one school's program has to be "sacrificed" for another program. Pressures on the colleges are tremendous to meet accreditation requirements since without this status potential students will not attend since their "career" options would be limited to a few states. The quality of education not only suffers but their continued operation is in jeapordy.

Presently, chiropractic colleges have no incentive to meet the problems of geographic maldistribution and inadequate female and minority representation in the profession. The schools have tremendous problems just meeting the needs of the current student population, much less recruiting and meeting the needs of students from underserved communities or minorities and women. Our colleges, as free standing independent institutions are in need of capital improvements. Many of their facilities were constructed years ago when the size of the student body and the demand for chiropractic services were far smaller than they are now. Many facilities are inadequate for contemporary quality chiropractic education and must be renovated. Satellite clinical centers are needed by many of our schools to provide not only a sufficient range of clinical experience for our students, but to provide service to many of our underserved and elderly citizens that travel great distances to receive care at our present clinics. Without federal funding in some form, our collegus will not be able to meet the needs for adequate teaching facilities. Progress and advancement in chiropractic education will move along at a pace which will not best serve the needs of this nation or of the strong commitment the federal government has made for health professional education.

The evolution of modern medicine and allied health professional education during the last thirty years has been closely tied to federal funding. Federal money has been granted to fund education in medicine, dentistry, osteopathy, podiatry, optometry, veterinary medicine, nursing, public health and pharmacy -- every aspect of the health care system except chiropractic. The exclusion of chiropractic from federal health manpower funds places the profession at a disadvantage in the maintenance of quality education. The exclusion is not in the best interest of either the public or this country's health care delivery system; nor is it consistent with many different federal programs which include chiropractic services.

Therefore, we respectfully request that when the present health manpower act is revised, it be amended to specifically provide for institutional support to chiropractic colleges. The items we feel this program should contain are:

(1) FINANCIAL ASSISTANCE GRANTS FOR NEW INSTITUTIONS

Within the past few years, four different chiropractic colleges have opened classes for the training of Doctors of Chiropractic. As the acceptance,* recognition and demand for chiropractic services increases, the need for new facilities will certainly increase. These new institutions will face tough, if not impossible, demands for financing unless federal funds are available for beginning faculty recruitment, equipment, facilities, library resources and other needs.

(2) FINANCIAL DISTRESS GRANTS

Our chiropractic colleges are not immune to the ever increasing burden of inflation. Added to this problem is the need to improve facilities and curriculum of existing schools at a standard which will assure and maintain accreditation, and most important, to open new facilities at a level that achieves accreditation. Therefore, our colleges should be allowed to participate in financial distress programs when they face serious financial problems; when they are in need of meeting, maintaining or seeking accreditation requirements; and for the carrying out of appropriate, operational managerial and financial reforms.

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* Recent indications of greater public acceptance can be shown by the appointment of two chiropractors to the United States Olympic Council on Sports Medicine. (appendix)

(3) CONSTRUCTION ASSISTANCE

Chiropractic colleges should be able to participate in any federally funded construction loan program. Without this source of security, many new facilities which are now inadequate could not be renovated or improved.

(4) SPECIAL PROJECT GRANTS

The Secretary should be allowed to make grants to chiropractic colleges to encourage the development of policies to attract and recruit students who are from medically underserved areas. The Secretary should also be allowed to make grants to chiropractic colleges which develop programs to provide services to areas which are medically underserved.

The particular needs of the medically underserved are no different from the millions of other citizens who seek chiropractic services. Additionally, the poor and the elderly have been in the past the most dependent users of chiropractic care. Often many of these individuals do not receive chiropractic care because of the great distances that have to be traveled to participate in the clinics. Our colleges would be most anxious to start programs that would provide needed care to the underserved and elderly who are far removed from our present facilities. Currently, lack of funds have prevented the establishment of such programs.

Project grants should be allotted for the development of didactic or clinical education especially continuing education and residency training in geriatrics, orthopedics and neurology, roentgenology, chiropractic technique, and clinical teaching methods. Project grants should also be made available to chiropractic colleges in nutrition, geriatrics, rehabilitation and the containment of healthcare costs. And project grants for attracting women and minority members should also be included.

(5) GRANTS

Additionally, chiropractic colleges should fully participate in any grant-giving program, be it grants for "national priority incentive programs" as in S-2375 or in the present capitation grants program if there is an extension of the current law. Such grants would virtually assure that chiropractic education reach contemporary needs and would expand the current state of chiropractic science. This is especially true since our colleges have never been the recipients of any federal funds.

STUDENT FINANCIAL ASSISTANCE

Doctors of chiropractic can provide valuable health and clinical services in the National Health Service Corps but have not had this opportunity. Doctors of Chiropractic will provide a professional and competent new dimension to the many community health care centers of many rural and urban underserved areas.

Scholarship and loan programs are necessary so that students will have an option and opportunity to acquire a chiropractic education when family or personal financial resources are inadequate or desperately short to meet educational costs. Without such programs, chiropractic colleges will remain the place for only the wealthy and white. These new programs would also assure that quality students would not be turned down from pursuing a career in chiropractic because the federal government does not provide financial support, as it does with other health care providers.

The chiropractic students should be included and should participate in financial aid programs such as:

(1) The National Health Service Corps Scholarships. A new NHSC program should clearly provide for the participation of chiropractic students. A set number of scholarships should be awarded to chiropractic students annually and the same number of entry level NHSC positions should be held for doctor of chiropractic in each year of a new authorization.

(2) Exceptional Financial Need Scholarship (EFN) The Secretary should be authorized to provide

grants to status holding chiropractic institutions for the awarding of scholarship grants to full-time students who are of exceptional financial need.

(3) Service Contingent Loan Program

Current law should be amended to include and provide that the Secretary shall enter into agreements at the request of chiropractic colleges to establish and operate a service contingent student loan program.

(4) Health Professions Student Loan Program

Any extension of the current Health Profession Student Loan Program, which we understand to be the most popular of the student assistance programs under current law, should specifically provide for chiropractic student participation.

(5) Federal Loan Insurance Program

Current law should be amended to include the participation of chiropractic students in the federal program for insured loans.

NATIONAL ADVISORY COUNCIL ON HEALTH PERSONNEL

The particular manpower problems of chiropractic would necessitate that the Department of Health and Human Services implement and maintain a systematic and ongoing program for the collection of data on chiropractic. Therefore, we respectfully request that legislation be adopted for the purpose of assuring that such data collecting is implemented and maintained by the appropriate division within the Department.

CONCLUSION

Chiropractic colleges are a unique national resource providing the sole quality education and instruction in the principle of spinal manipulative therapy. The Congress has several times recognized the unique contribution that chiropractic can make in alleviating health care problems in this country. The American citizenry utilizes and demands chiropractic care.

The time has come for the Congress to follow through with this recognition by designing legislation which will allow our colleges (and students) to participate as a separate and equal partner in the federally funded health manpower training programs. This legislation would assure that quality education be maintained. Our profession is dedicated to the ever present need to train primary care practitioners that specialize in spinal manipulative therapy. Our colleges are well qualified to meet this need. We look forward to an opportunity to meet with individuals directly involved in shaping the nation's health manpower policy, and we are anxious for ongoing and mutually productive dialogue. We would be most happy to provide any other information which may be needed. Thank you.

APPENDIX

DEMOGRAPHIC CHARACTERISTICS

DISTRIBUTION OF DC'S ACROSS THE UNITED STATES AND RELEVANT DC POPULATION RATIOS FOR 1978 POPULATION ESTIMATES.*

REGION SUB-REGION STATE	TOTAL NUMBER OF DC'S	POPULATION ESTIMATE (1978 ESTIMATE THOUSANDS)	DC POPULATION RATIO (PER 100,000)
NATIONAL TOTAL	21,383	219,768.5	10.3
NORTH CENTRAL REGIONS	6,134	58,451.5	10.5
EAST NORTH CENTRAL	3,503	41,321.1	8.5
ILLINOIS	962	11,289.4	8.5
INDIANA	440	5,361.4	8.2
MICHIGAN	872	9,201.3	9.5
OHIO	671	10,769.0	6.2
WISCONSIN	558	4,700.0	11.9
WEST NORTH CENTRAL	2,631	17,130.4	15.4
IOWA	678	2,917.2	23.2
KANSAS	462	2,366.0	19.5
MINNESOTA	524	4,040.7	13.0
MISSOURI	686	4,859.8	14.1
NEBRASKA	95	1,583.0	6.0
NORTH DAKOTA	71	660.9	10.7
SOUTH DAKOTA	115	702.8	16.4
SOUTHERN REGIONS	5,253	71,353.5	7.4
SOUTH ATLANTIC	2,408	34,981.7	6.9
DELAWARE	38	587.3	6.4
DISTRICT OF COLUMBIA	6	677.5	.9
FLORIDA	1,123	8,766.4	12.8
GEORGIA	399	5,110.6	7.8
MARYLAND	158	4,185.2	3.8
NORTH CAROLINA	311	5,627.1	5.5
SOUTH CAROLINA	215	2,934.9	7.3
VIRGINIA	93	5,210.3	1.8
WEST VIRGINIA	65	1,882.5	3.5
EAST SOUTH CENTRAL	1,044	14,093.2	7.4
ALABAMA	270	3,770.1	7.2
KENTUCKY	405	3,524.2	11.5
MISSISSIPPI	209	2,418.2	8.6
TENNESSEE	160	4,380.7	3.7

*NOT ADJUSTED FOR RETIREMENT AND NEW LABOR MARKET ENTRANTS.

1977-1979 Study of Education and Manpower in the Chiropractic Profession

DISTRIBUTION OF DC'S ACROSS THE UNITED STATES AND RELEVANT DC POPULATION RATIOS FOR 1978 POPULATION ESTIMATES.*

REGION SUB-REGION STATE	TOTAL NUMBER OF DC'S	POPULATION ESTIMATE (1978 ESTIMATE IN THOUSANDS)	DC POPULATION RATIO (PER 100,000)
WEST SOUTH CENTRAL	1,801	22,278.6	8.1
ARKANSAS	166	2,194.5	7.6
LOUISIANA	247	3,986.2	6.2
OKLAHOMA	346	2,926.7	11.8
TEXAS	1,042	13,171.2	7.9
NORTHEASTERN	4,032	49,442.8	8.2
NEW ENGLAND	738	12,343.6	6.0
CONNECTICUT	133	3,137.9	4.2
MAINE	68	1,100.0	6.2
MASSACHUSETTES	287	5,802.1	4.9
NEW HAMPSHIRE	156	875.7	17.8
RHODE ISLAND	37	935.7	4.0
VERMONT	57	492.2	11.6
MIDDLE ATLANTIC	3,294	37,099.2	8.9
NEW JERSEY	685	7,343.2	9.3
NEW YORK	1,482	17,938.7	8.3
PENNSYLVANIA	1,127	11,817.3	9.5
WESTERN REGIONS	5,964	40,520.7	14.7
MOUNTAIN	1,357	10,460.9	13.0
ARIZONA	360	2,418.2	14.9
COLORADO	358	2,710.3	13.2
IDAHO	90	892.0	10.1
MONTANA	101	783.8	12.9
NEVADA	77	668.0	11.5
NEW MEXICO	175	1,229.7	14.2
UTAH	145	1,321.3	11.0
WYOMING	51	437.6	11.7
PACIFIC	4,607	30,059.8	15.3
ALASKA	36	427.8	8.4
CALIFORNIA	3,550	22,482.0	15.8
HAWAII	43	911.5	4.7
OREGON	348	2,462.3	14.1
WASHINGTON	630	3,766.2	16.7

*NOT ADJUSTED FOR RETIREMENT AND NEW LABOR MARKET ENTRANTS.

1977-1979 Study of Edu[illegible] and Manpower in the Chiropractic Profession

DISTRIBUTION OF PRACTICING DC'S ACROSS THE UNITED STATES
CENSUS REGIONS AND RELEVANT POPULATION RATIOS
FOR 1978 POPULATION ESTIMATES*

REGION SUB REGION	NUMBER OF DC'S IN SAMPLE	PERCENT NOT ACTIVE	NUMBER OF RECENT GRADS. ENTERING	NUMBEROF DC'S (EST.)	ACTIVE DC POPULATION RATIO
NORTH CENTRAL	6,134	6.2%	807	6,561	11.2
EAST NO. CENTRAL	3,503	6.1%	484	3,773	9.1
WEST NO. CENTRAL	2,631	6.3%	323	2,788	16.3
SOUTH	5,253	7.3%	766	5,636	8.0
SO. ATLANTIC	2,408	4.6%	432	2,729	7.8
EAST SO. CENTRAL	1,044	16.0%	76	953	6.8
WEST SO. CENTRAL	1,801	8.1%	258	1,913	8.6
NORTHEAST	4,032	4.9%	578	4,414	8.9
NEW ENGLAND	738	1.3%	119	847	6.9
MIDDLE ATLANTIC	3,294	6.7%	459	3,532	9.5
WEST	5,964	20.5%	939	5,680	14.0
MOUNTAIN	1,357	26.3%	195	1,195	11.4
PACIFIC	4,607	16.7%	742	4,580	15.2
TOTAL	21,383		3,090	22,291	

*ADJUSTED FOR NEW ENTRANTS AND RETIREMENTS.

1977-1979 Study of Education and Manpower in the Chiropractic Profession

SIZE OF TOWN IN WHICH ACTIVE DC'S MAINTAIN PRACTICES AND IN WHICH RECENT GRADUATES ENTER PRACTICE

SIZE OF TOWN	PORTION OF D.C.s IN PRACTICE	PORTION OF RECENT GRADUATES ENTERING PRACTICE
SMALL TOWN (UNDER 2,500)	10.2%	7.7%
LARGE TOWN (2,500 TO 24,999)	30.5%	28.7%
SMALL CITY (25,000 TO 99,999)	26.1%	26.8%
LARGE CITY (OVER 100,000)	24.1%	22.0%
SUBURB OF LARGE CITY	9.2%	14.9%
	100%	100%
	N = 1,481	N = 1,790

1977-1979 Study of Education and Manpower in the Chiropractic Profession

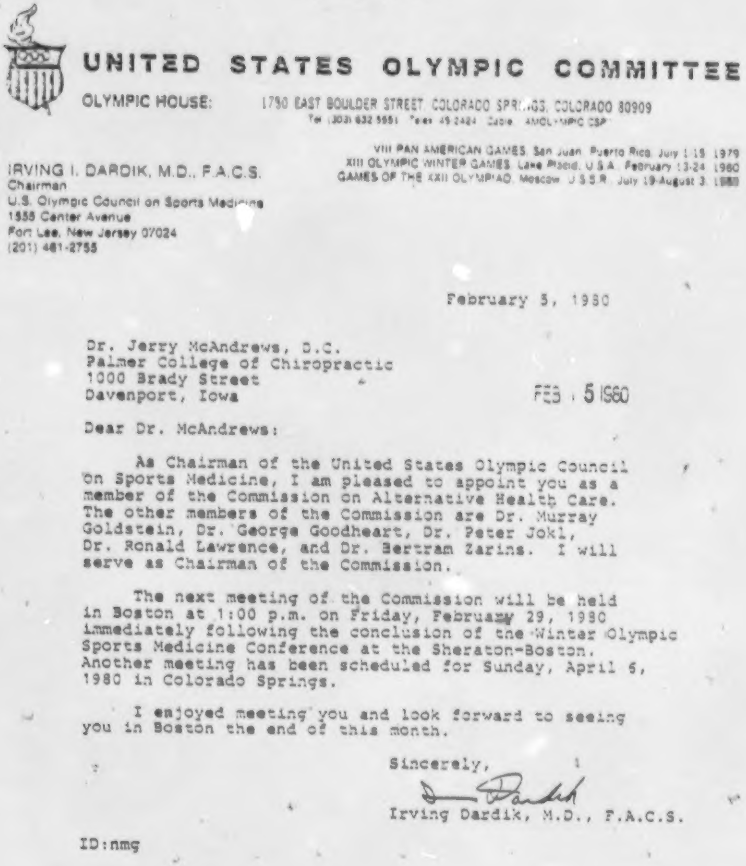
FACTORS SEEN BY PRACTICING D.C.S LEADING TO INCREASED DEMAND FOR THEIR SERVICES

	Percent of respondents mentioning this factor
Greater public education about chiropractic	85.4%
Increasing acceptance/prestige of the profession among other health professions	63.5%
Expansion in kinds of services reimbursable by third-party payors	61.0%
Increase in amount third-party payor will reimburse per service delivered	51.9%
A national definition of D.C. services or a more consistent scope of practice from state to state	37.3%
Wider scope of practice for chiropractic (change in state laws)	27.5%
Increased number of D.C.s practicing in your area	24.7%
Decreased number of D.C.s practicing in your area	7.5%

N=1488

1977-1979 Study of Education and Manpower in the Chiropractic Profession

OLYMPIC LETTER



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GAMES OF THE XXII OLYMPIAD, Moscow, U.S.S.R., July 19-August 3, 1980

IRVING I. DARDIK, M.D., F.A.C.S.
Chairman
U.S. Olympic Council on Sports Medicine
1555 Center Avenue
Fort Lee, New Jersey 07024
(201) 461-2755

February 5, 1980

Dr. Jerry McAndrews, D.C.
Palmer College of Chiropractic
1000 Brady Street
Davenport, Iowa

FEB 5 1980

Dear Dr. McAndrews:

As Chairman of the United States Olympic Council on Sports Medicine, I am pleased to appoint you as a member of the Commission on Alternative Health Care. The other members of the Commission are Dr. Murray Goldstein, Dr. George Goodheart, Dr. Peter Jokl, Dr. Ronald Lawrence, and Dr. Bertram Zarins. I will serve as Chairman of the Commission.

The next meeting of the Commission will be held in Boston at 1:00 p.m. on Friday, February 29, 1980 immediately following the conclusion of the Winter Olympic Sports Medicine Conference at the Sheraton-Boston. Another meeting has been scheduled for Sunday, April 6, 1980 in Colorado Springs.

I enjoyed meeting you and look forward to seeing you in Boston the end of this month.

Sincerely,

I. Dardik

Irving Dardik, M.D., F.A.C.S.

ID:nmg

A Study of Time Loss Back Claims

Workmen's Compensation Board, State of Oregon

Because back injuries seem to be a continuing perplexity to the professions, the insurers, the employers, and the agencies who administer workmen's compensation laws, this study of a limited number of claims was initiated.

This study began one year prior to the writing of this paper. Initially all time loss back injury claims received in our Compliance Division for a period of one month were examined and certain basic information was recorded.

One year later these same claims were re-examined. There are a total of 237 claims in this study. They are claims which are not complicated by other bodily injuries or illness. Thus, back injury in either the cervical, dorsal, or lumbar areas, or combinations thereof, is the essential problem.

The average age of these workmen is 40.16 years. The range of ages is from 17 years to 68 years. Breaking this down in age groups we see the following:

17 - 20	2.8%
20 - 30	22.0%
30 - 40	22.4%
40 - 50	24.9%
50 - 60	19.8%
60 - 70	6.3%
Unknown	2.1%

Thus we can see the bulk of these claimants fall into the 30-50 year category. They have approximately 15-35 years of working life remaining, in theory.

Twenty-eight of the claimants are females. This gives us approximately a 8:1 ratio of male:female claimants. The occupations of all claimants range from what can be considered sedentary to hard manual labor. Most claimants do manual labor of some form in their day to day jobs.

Time loss:

Examining the periods of time loss from work shows 66% of the workmen's claims are closed by the end of 8 weeks. A total of 81% of the claims are closed by the end of 41 weeks of time loss. The remaining 19% of the claims remain open after one year.

Thus it appears from this sample of back injury claims, we might expect four-fifths of our workmen will return to work within one year or less from the date of their injury. One fifth of our workmen will still be receiving time loss payments beyond one year from the day of injury.

Treatment and time loss:

The majority (212 workmen) were treated by various conservative methods. Surgery was performed on twenty-five claimants. Of these, eleven claims are now closed with less than one year of time loss. All eleven claimants had hemilaminectomies except one man who had a rhizotomy.

Fourteen workmen, or 56% of those operated, remain on time loss after one year from the day of injury. All but three had laminectomies. Two claimants had a laminectomy and fusion. One other workman received a spinal fusion.

Examining the forms of conservative therapy the majority received, it is interesting to note the results of those treated by chiropractic physicians.

A total of twenty-nine claimants were treated by no other physician than a chiropractor. 82% of these workmen resumed work after one week of time loss. Their claims were closed without a disability award.

Examining claims treated by the M.D., in which the diagnosis seems comparable to the type of injury suffered by the workmen treated by the chiropractor, 41% of these workmen resumed work after one week of time loss.

Disability awards:

Of the 193 claims closed prior to one year of time loss, 15.5% were granted permanent partial disability awards. Seen below is the distribution of awards.

Award	16°	32°	48°
Number of Claimants	7	15	8

A more detailed examination of the claims of those workmen receiving the greatest award of 48° was made and is shown in the following table. All but one are above the average age. No correlation exists between the degree of the award and time loss. Less than one half have had prior back injury.

Disability Awards of 48"

Age	Diagnosis	Treatment	Time Loss	Prior Inj.	Prior Award
57	Lumbosacral strain Degenerative arthritis	Conserv.	11 wks	No	Unknown
55	Strain. Degenerative disc disease	Conserv.	20 wks	Yes	No
48	Herniated inter-vertebral disc	Laminectomy	41 wks	No	Unknown
33	Compression fracture T-8, T-9	Conserv.	4 wks	Yes	No
46	Compression fracture L-2	Conserv.	40 wks	No	Unknown
58	Acute lumbosacral strain	Laminectomy	23 wks	No	Unknown
57	Herniated inter-vertebral disc	Laminectomy	20 wks	Yes	Unknown
55	Degenerative disc disease	Conserv.	27 wks	No	No

Open Claims:

a.) There are 19% of the claims in an open status after one year of time loss. The diagnosis given in 31% of these claims is Herniated Intervertebral Disc. Cervical, dorsal, or lumbar strain, or combinations thereof, is the diagnosis given in 50% of these claims. The remaining 19% have various diagnostic titles attached to the back injury.

Fourteen claimants have been treated surgically, as seen in the following table.

Laminectomy	- 11
Fusion	- 1
Laminectomy and fusion	- 2

The remaining thirty workmen are under conservative care.

b.) Treating physicians:

General practitioners are considered to be the initial or treating doctor in 47% of these claims. Orthopedics are the initial physician in 25%. The remainder show chiropractors, osteopathic physicians, neurosurgeons, surgeons and internists as the initial treating doctor.

c.) Consultants:

All but five of these forty-four workmen have been referred for consultation to one or more medical specialists. Orthopedists act as consultants 54.8% of the time. Neurosurgeons or neurologists are consultants in 31.8% of those referred.

d.) Rehabilitation:

Referral to the Workmen's Compensation Board's Physical Rehabilitation Center occurred in nine claims. Six of these workmen were referred on for vocational rehabilitation. Two workmen were apparently referred directly to DVR who did not enroll in P.R.C.

Of these six workmen considered as possible candidates for vocational rehabilitation, none are being trained. One was considered "functionally illiterate." One began training in graphic arts, but dropped the course and is wanting to become a truck driver. Another was considered untrainable. No vocational objective has been decided upon for another, at this time. One man was declared ineligible because of age, lack of training and job market. Finally, the sixth man was not referred because his disability was not found to be great enough. So it appears we have a 100% failure rate in this group of claimants.

Summary:

If we can use this sampling as an indicator, we can assume the average workman who injures his back at work will be about 40 years of age. He will probably receive conservative treatment. There is a 66% chance he will not lose more than eight weeks work, and there is only a 15% chance there will be any permanent partial disability resulting from his injury.

Of all the workmen who injure their backs at work, one-fifth will continue in a time loss status beyond one year. There is a 31% chance this group will undergo surgical treatment.

Utilization of our physical rehabilitation center occurred in 3.3% of these claimants, two-thirds of whom were referred for consideration of vocational rehabilitation. But, in this study, it was for naught.

Rolland A. Martin, M.D.
Medical Director
Workmen's Compensation Board

March 1971

STUDENT ENROLLMENT AT CHIROPRACTIC COLLEGES OVER THE PAST TEN YEARS

Year	Cleve-Land (KC)	Cleve-Land (LA)	Life	Logan	Los Ange-les	Nat-ional	New York	North West-ern	Palmer	Pasa-dena	Sher-man	Texas	Wes-tern States	North-ern Cali-fornia	Pac-ific States
1969*	172	**		219	191	276	178	61	1026			92	**		
1970	151	**		219	183	272	180	78	1034			80	38		
1971	161	**		226	183	335	190	92	1149			96	62		
1972	174	**		341	194	420	220	105	1343			109	86		
1973	236	**		371	269	558	294	127	1027			147	137		
1974	372	440		493	401	716	374	194	2045	107	**	171	182		
1975	361	411	137	460	439	790	535	284	2051	75	**	199	291		
1976	301	365	297	515	510	836	570	334	1799	187	**	244	402		
1977	230	295	535	529	638	859	658	352	1971	174	367	296	432		
1978	231	311	861	557	609	870	645	307	1816	193	380	309	498	90	60

*Bottom of decline in student enrollment trend starting from the early 1960s.
**No figures available but college in operation.

1977-1979 Study of Education and Manpower in the Chiropractic Profession

Industrial Back Injury

(Study Completed in
December, 1972)

By
C. Richard Wolf, M.D.

*Special Credit is given to
Dr. Floyd R. Hill.*

A comparison of patient-reported time loss-treated by medical doctors vs. treated by chiropractors.

BACKGROUND

The total number of disabling back injuries reported to the Calif. Division of Labor Statistics and Research more than doubled during the years 1950-1970. The rate of lost-time back injuries per 1,000 employed workers has been relatively stable, ranging from a low of 6.9 in 1957 to a high of 7.5 in 1965 and 7.4 at the end of the period in 1970. However, back injuries have risen as a proportion of total lost-time work injuries from a low of 17.6% in 1950 to a high of 24.1% in 1970. This would imply that attempts to prevent lost-time back injuries have not been as successful as those of other accident problems since no reporting artifacts appear to explain this phenomenon.[1]

According to the California State Labor Code, all illnesses arising out of conditions of employment are defined as injuries and must be reported by practitioners to the California Department of Industrial Relations. These reports entitled "Doctor's First Report of Work Injury", have been analyzed, tabulated and published as epidemiologic studies by this author on previous occasions.[2 3 4] It seemed appropriate, therefore, to utilize these reports to study the problem of lost time from back injuries. Problems of under-reporting, incomplete reporting and, on occasion, inaccurate reporting exist and have been studied and discussed.[5] It is of considerable significance that these reports describe only the first visit to a practitioner and therefore little can be learned about time loss except as estimated on some reports. After reviewing many reports, it became apparent that many injured employees were electing to visit a chiropractor for treatment of their back injuries. Martin[6] studied 237 time-loss back claims. Twenty-nine claimants were treated by no other practitioner than a chiropractor with 82% of these resuming work after one week of time loss. Their claims were closed without a disability award. He examined claims treated by medical doctors in which the diagnosis seemed comparable to the type of injury suffered by the workmen treated by the chiropractors; 41% of these workmen resumed work after one week of time lost. He further stated that no conclusions should be drawn on such a small study, that these findings were only one observation of the overall study, but, that serious studies of the different treatment modalities and comparisons of the success ratio are sorely needed.

This present study was designed to compare time loss due to industrial back injury when treated by either a chiropractor or a medical doctor, using the records of the Division of Labor Statistics and Research (Doctor's First Report of Work Injury).

STUDY DESIGN

The Division of labor Statistics receives and sorts over 1,000,000 first reports each year. At the author's request, 500 back injury reports signed by M.D.'s and 500 signed by chiropractors were consequently selected as they arrived in the mail.

When these reports were reviewed, it was obvious that no conclusions could be drawn regarding comparability of diagnosis. The very nature of the difference in treatment philosophy excluded the possibility of having comparable diagnostic categories. Furthermore, the factor of case selection was built into the study by virtue of the fact employees voluntarily selected either an M.D. or a chiropractor.

Since diagnoses were not comparable, self-selection of cases was unavoidable and no reliable information could be obtained about time loss from the report. It was decided that each employee would be contacted using the report only as source of cases for the study.

A short form letter was sent to each of the 1,000 injured employees. Referring to the specific doctor visit reported, the letter read as follows:

> "Our office reviews selected copies of Doctor's First Report of Work Injury with the aim of prevention of illness in workers."
>
> "Back injuries are a large percentage of work injury reports. In the hope of learning something which may be useful in preventing illness from back injuries, we would appreciate more information about the work injury report, when you were seen by ________ on __________ The information you give will be used as a statistical tabulation only. *This has nothing to do with allowance of claim or payment of claims.*
>
> (1) How much time did you lose from work with this injury? (   )
>
> (2) Do you still have pain or stiffness at the site of this injury?
> Yes (   )   No (   )
>
> (3) Are you completely over this episode so far as you can tell?
> Yes (   )   No (   )
>
> "A postage-free envelope is enclosed for your convenience in returning this query."

When about 475 responses had been received and additional ones were arriving only occasionally, a second mailing was made to all who had failed to respond and an additional question was added:

(4) Did you consult any other doctor before the one above; if so, was it a chiropractor or medical doctor? Of the 82 responding to this letter who had visited a chiropractor on the Doctor's First Report, 16 had first gone to an M.D. Of the 95 responding who had gone to an M.D. on the Doctor's First Report, 9 had first gone to a chiropractor.

Table I is a tabulation of responses to the questions.

Table I

	Employees Treated by Medical Doctors (M.D.'s)	Employees Treated by Doctors of Chiropractic (D.C.'s)
Number of Employees Sent questionaire	500	500
Number of Employees Responding	333	296
Average Age of Employees Responding	39.7 years	42.9 years
Percent Female Employees	20.4%	13.8%
Total Lost Time (days)	10,641 days	4,627 days
Average Lost Time (days per Employee)	32 days	15.6 days
Percent Employees Reporting Complete Recovery	34.8%	51%
Percent Employees Reporting No Lost Time	21%	47.9%
Percent of Reporting Employees Losing Over 60 days	13.2%	6.7%
Percent of Reporting Employees Given Diagnosis of Strain or Sprain	69%	82%

DISCUSSION

Of the original 1,000 injured employees who were sent letters, replies were obtained from 629, for an overall 63% response. 333 patients treated by M.D.'s responded and 296 patients treated by chiropractors responded. All letters returned due to address change in both categories were followed up by telephone and in the most cases the information was obtained verbally from these. The remaining cases that were sent a second letter without response were not followed up further.

A remarkable similarity in diagnoses was recorded by both groups. Either "strain" or "sprain" was written on the First Report by 69% of M.D.'s and 82% of chiropractors (of patients responding). It is the author's opinion that this reflects a reporting requirement of the agencies paying for the doctor visit with which both groups must comply, rather than representing a true agreement on underlying pathology.

In attempting to determine any difference in the two population groups, the only employment category that appeared significantly different between the two groups was the category "Nurses and L.V.N.'s". This accounted for the majority of the sex difference between the groups. 17 of 68 female injured employees treated by M.D.'s were nurses or L.V.N.'s, whereas only 1 of 41 female employees treated by chiropractors was a nurse. There was no significant difference in employment categories observed in males between the two groups. Both groups were made up equally of carpenters, laborers, mechanics, custodians, waitresses, truck drivers, etc.

The significant differences between the two groups appear to be as follows:

> Average lost time per employee — 32 days in the M.D.-treated group, 15.6 days in the chiropractor-treated group.
>
> Employees reporting no lost time — 21% in the M.D.-treated group, 47.9% in the chiropractor-treated group.
>
> Employees reporting lost time in excess of 60 days-13.2% in the M.D.-treated group, 6.7% in the chiropractor-treated group.
>
> Employees reporting complete recovery-34.8% in the M.D.-treated group, 51% in the chiropractor-treated group.

CONCLUSION

The author cannot explain these differences by any bias in study design, nor is there anything in the study to permit speculation as to relative treatment merits. Therefore some explanation remains to come forth.

SUMMARY

One thousand employees with industrial back injuries were questioned about the time lost and residual pain from their injuries. One-half of these injuries were reported as having been treated by medical doctors, the other half by chiropractors. Responses were obtained from 629. There were no apparent major indentifiable differences in the two groups with regard to age or employee categories. The major differences were: (1) employee statement of lost time; 32 days average for M.D.-treated group versus 15.6 days average for the chiropractor-treated group; (2) percentage of employees reporting lost time in excess of 60 days; 13.2% of those treated by M.D.'s versus 6.7% of those treated by chiropractors; and (3) percent of employees reporting no lost time; 21% of those treated by M.D.'s versus 47.9% of those treated by chiropractors.

The author is unable to explain these differences.

BIBLIOGRAPHY

1. California Work Injuries 1970 State of California Department of Industrial Relations Division of Labor Statistics and Research. 455 Golden Gate Avenue, San Francisco, Ca.
2. Wolf, C.R., Aeortitis in Air Travel California Medicine 117:10-12 November, 1972.
3. Wolf, C.R., Baginsky, E., Milby, T.H.: Patterns in Occupational Disease J. Occ. Med. 12:1-5 Jan. 1970.
4. Milby, T.H.; Wolf, C.R.: Respiratory Tract Irritation from Fibrous Glass Inhalation J. Occ. Med. 3: 449, 1961.
5. Berkov, B.M.; Kleinman, G.D.; Powers J.E., and Trasko V.M.; Evaluation of Occupational Disease Reporting in California J. Occ. Med. 3: 449, 1961.
6. Martin, R.A., M.D., Medical Director Workman's Compensation Board, State of Oregon Salem, Oregon 97310. Personal Communication, 1972.

Occasional Survey

MANIPULATING THE PATIENT

A COMPARISON OF THE EFFECTIVENESS OF PHYSICIAN AND CHIROPRACTOR CARE

ROBERT L. KANE CRAIG LEYMASTER
DONNA OLSEN F. ROSS WOOLLEY
F. DAVID FISHER

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Summary Patients identified through Workmen's Compensation records as having been treated for back or spinal problems by a chiropractor (122) or a physician (110) were interviewed to determine their functional status before and after the accident and their satisfaction with the care received. In terms of both the patients' perception of improvement in functional status and patient satisfaction, the chiropractors appear to have been as effective with the patients they treated as were the physicians. The two groups of patients were not significantly different with regard to age, sex, race, education, marital status, income, hypochondria, or attitudes about the medical profession in general.

INTRODUCTION

THE medical profession's disdain for chiropractic has existed since the first emergence of the practice at the end of the nineteenth century. None the less, the public turns to chiropractors for assistance in ever more substantial numbers. Kuby cites two studies from the mid-1950s which suggest that 5–7% of the families surveyed had consulted a chiropractor during the previous year. Over 16% of the respondents expressed a willingness to use such a practitioner.[1]

Despite the opposition of organised medicine, chiropractors are now eligible for reimbursement under Medicare as a result of PL 92–603. Ballantine represents the position of many physicians [2]:

> "The inclusion of chiropractic in any health care program, public or private, is not in the public interest. There is no reason to believe that further studies of chiropractic would bring forth new facts to negate the findings previously published by knowledgeable investigators of unquestionable integrity."

Ironically, there is a scarcity of scientific data on the validity of chiropractic theory or the effectiveness of chiropractic therapy. The first experimental study of the basis for the theory of vertebral manipulation to be published in a recognised scientific journal appeared in 1973.[3] However, the public continues to find solace in the services offered by these practitioners, as evidenced by the continued use of their services. In recognition of this public support and prompted by the current medical furore over the Medicare regulations, we felt it appropriate to attempt an evaluation of the effectiveness of chiropractic treatment, regardless of the theoretical validity of the methods. If chiropractors are able to improve their patients' functional levels, as judged by the patients themselves, this evidence would be a first step in bringing factual data and rational discussion to an overheated subject.

METHODS

To establish our sample, we reviewed all claims of the Utah State Insurance Fund (Workmen's Compensation) between July and December, 1972, to identify neck and back injuries (table I). From these, those patients living within an hour's travelling time from the university were listed. Workmen's Compensation permits the injured worker to select his therapist from among physicians,

TABLE I—UTAH STATE INSURANCE FUND WORKMEN'S COMPENSATION NECK AND BACK INJURIES, JULY–DECEMBER, 1972

	Statewide	Target area
M.D. patients	482 (*60%*)	336* (*55%*)
D.C. patients	175 (*22%*)	147† (*24%*)
D.O. patients	14 (*2%*)	13 (*2%*)
Both (M.D. and D.C.)	47 (*6%*)	44 (*7%*)
Type of practitioner consulted not clear in records	77 (*10%*)	67 (*11%*)
	795 (*100%*)	607 (*100%*)

* 145 randomly sampled for this study.
† Included in study.

osteopaths, and chiropractors. For the study period and geographical area specified, records were identified for 147 chiropractor (D.C.) patients and 336 medical (M.D.) patients; 13 patients had used osteopaths and 44 had consulted both a physician and a chiropractor. For 67 cases the type of therapist was unclear. A random sample of physician patients approximately equal in number to the chiropractic patient group was made.

Efforts were made to interview each of these patients in his own home. A questionary was designed to supply data on (1) the type of practitioner visited, the number of visits, treatments used, and the source of referral; (2) patient satisfaction with the therapist and the care received; (3) the degree of functional improvement achieved; (4) the patient's attitudes toward the medical profession; and (5) the general level of patient hypochondria.

We used the technique developed by Bush[4] to estimate the functional status of the patient prior to his injury (T_1), at the time of the first visit to a therapist (T_2), and at the point of the interview (T_3). These functional levels were computed by combining three scores—the patient's degree of body movement, travel and confinement, and activity for each point in time. These values were converted to a continuous scale from which ratios could be derived to compare the function at one point in time in terms of that of another. In the ratio used,

$$\frac{(T_3-T_2)}{(T_1-T_2)},$$

the numerator measures the extent of improved function after treatment and the denominator reflects the amount of disability imposed by the injury. The entire ratio then reflects the degree to which therapy improved function, relative to the severity of the disability produced by the injury. The higher the ratio, the more effective the treatment. (In using this ratio, we elected to omit six chiropractor patients and one physician patient who exhibited perfect functional scores at all three points in time.)

Questions on the patients' attitudes toward the traditional medical-care system and the medical profession were adapted from scales developed by Hulka et al.[5] to assess perceptions about professionalism, cost and convenience, and personal qualifications. The only alteration was the substitution of "physician" for "doctor" in several questions to avoid any confusion in the patient's mind with chiropractors.

The hypochondria scale used was developed by Pilowsky[6] and analyses three factors of hypochondria: (1) disease phobia, (2) bodily preoccupation, and (3) degree of conviction about the presence of a serious disease.

RESULTS

As shown in table I, at least 30% of persons suffering from neck and/or back injuries during the six-month period from July to December, 1972, consulted someone other than a medical doctor. This proportion was slightly larger for the geographically defined target area of the study, probably because of the clustering of chiropractors and osteopaths in the more urban areas. Of the 145 physician patients sampled, 110 (76%) were interviewed; 10 patients refused to participate; 25 either had moved from the area or could not be located. For the chiropractor patients, 122 of the 147 in the sample (84%) were interviewed—5 refused and 20 could not be found. The overall response-rate for the study was 80%. This left a study sample of 110 M.D. patients and 122 D.C. patients.

TABLE II—CHARACTERISTICS OF PHYSICIAN AND CHIROPRACTOR PATIENTS

Characteristic	M.D. patients (N = 110)	D.C. patients (N = 122)	P-value
Mean age (yr.) ..	35·4	37·6	N.S.
Race (% White)	92	96	N.S.
Sex (% male)	85	85	N.S.
Mean educational level (yr.)	12·1	12·1	N.S.
Modal income range ($) ..	5000–10,000	5000–10,000	N.S.
Mean Hulka scale scores of attitudes towards the medical profession:			
Professionalism	49·5	49·5	N.S.
Cost and convenience ..	73·1	73·1	N.S.
Professional qualifications	64·2	63·9	N.S.
Mean hypochondria scores:			
Disease phobia	4·6	4·5	N.S.
Bodily preoccupation ..	4·5	4·4	N.S.
Degree of conviction about presence of serious disease	2·9	2·9	N.S.
Total score	3·4	3·3	N.S.

To look for possible selection bias, those patients who could not be interviewed but for whom data were available from Workmen's Compensation records were compared to the respondents. These data included the source of care, and thus we were able to compare chiropractor and physician non-respondents with their respective respondent groups. There was no significant difference in the sex ratio or marital status between respondents and non-respondents among either the chiropractic or medical patients. Nor was there any difference in age among the medical patients; however, among the chiropractic patients the respondents' average age was 6 years more than that of the non-respondents, a significant difference at the 0·05 level by *t*-test. The data presented in the remainder of this paper will deal only with respondents.

Table II summarises the demographic characteristics of the respondents. There were no statistically significant differences between respondents treated by physicians and chiropractors with regard to age, race, sex, educational background, marital status,

TABLE III—TREATMENT AND EFFECTIVENESS

	M.D. patients (N = 110)	D.C. patients (N = 122)	P value*
Mean no. of visits ..	7·3	12·8	< 0·001
Mean duration of treatment (wk.)	9·3	6·5	< 0·05
Mean no. of visits/week ..	1·2	2·5	< 0·001
Average functional status before disability ..	0·79	0·78	N.S.
Average functional status at time of first visit to practitioner	0·53	0·57	< 0·001
Current average functional status	0·75	0·76	N.S.
Mean ratio of functional status improvement† ..	0·86	0·92	N.S.
% returned to former status	70	80	N.S. by Mantel-Haenszel ($\chi^2 = 2·1$, $p > 0·10$)
% improved but not to former status	28	18	
% deterioration after treatment	2	2	

* By *t*-test unless otherwise indicated.

† Omits 6 D.C. patients and 1 M.D. patient who had perfect functional scores at T_1, T_2, and T_3.

income, attitudes towards the medical profession, or hypochondria.

Of the 110 patients who saw a physician, 60 consulted general practitioners and 50 saw a specialist. Physician patients were most likely to have been referred by a fellow worker or by another practitioner; most of the chiropractor patients were either self-referred or referred by a relative or fellow worker.

Table III compares the extent of treatment and functional-status changes achieved by the physicians and chiropractors. Generally, chiropractors required almost twice as many visits of their patients as did physicians. The mean number of physician visits was 7·3, compared to 12·8 for chiropractors. This is a significant difference. On the other hand, mean duration of treatment was significantly longer for M.D. patients—9·3 weeks as opposed to only 6·5. The physicians thus averaged 1·2 visits per week compared to 2·5 for chiropractors.

Functional status of both groups of patients did not differ significantly in terms of their initial and final levels. However, those who saw a physician were significantly more disabled at the time of their first visit than were chiropractic patients. There was some variation in the change in functional status achieved by the different therapists. On the basis of the ratio of improvement previously defined, the physicians were somewhat less effective, with a mean ratio of 0·86 compared with 0·92 for the chiropractors. It should be noted that this ratio omits 6 chiropractor patients and 1 physician patient who reported perfect functional scores consistently across T_1, T_2, and T_3 levels.

TABLE IV—NUMBER OF VISITS TO THERAPIST AND DURATION OF TREATMENT BY FUNCTIONAL STATUS AT TIME OF FIRST VISIT

Functional status at time of first visit (T_1)	Average no. of visits		Average duration (wk.)	
	M.D. patients (N = 110)	D.C. patients (N = 122)	M.D. patients (N = 110)	D.C. patients (N = 122)
Severe impairment	10·9	16·7	15·3	7·6
Moderate impairment	5·6	12·1	6·1	5·6
Mild impairment	7·4	12·6	6·0	6·2
	(F = 9·67, $p < 0·01$)	(F = 1·08, n.s.)	(F = 10·15, $p > 0·01$)	(F = 1·04, n.s.)

Table IV shows the difference in the chiropractors' and physicians' treatment schedules, according to the disability of their patients. The more severely disabled M.D. patients had a statistically significantly greater number of visits for a longer period of time than did the less severely disabled M.D. patients. This was not true for chiropractor patients. The difference in number of visits by chiropractor and M.D. patients was significant at the 0·001 level; the difference in duration of care was significant at the 0·04 level.

Table V compares the outcome of care with these same measures of therapeutic intensity. For chiropractor patients, there is a tendency for those who showed the least improvement to have had the most therapy. This was statistically significant in terms of number of visits, but not in terms of duration of treatment. Among M.D. patients there were significant variations but in no specific direction. Once again the differences between practitioners were statistically significant. For number of visits the significance level was <0·001; for duration, <0·03. In these analyses the seven patients mentioned above who showed consistently perfect functional scores over time were again omitted.

TABLE V—OUTCOME ACCORDING TO INTENSITY OF THERAPY

Outcome	Average no. of visits		Average duration (wk.)	
	M.D. patients (N = 109*)	D.C. patients (N = 116†)	M.D. patients (N = 109*)	D.C. patients (N = 116†)
Returned to former status	5·6	11·5	6·3	6·3
Improved but not to former status	12·5	16·3	16·9	7·1
Deteriorated or no change after treatment	3·1 (F = 6·58, $p < 0·01$)	30·0 (F = 4·30, $p < 0·025$)	7·4 (F = 9·66, $p < 0·001$)	9·3 (F = 0·293, n.s.)

* Omits 1 M.D. patient who had perfect functional scores at T_1, T_2, and T_3.

† Omits 6 D.C. patients who had perfect functional scores at T_1, T_2, and T_3.

Treatment employed varied among practitioners. Physicians used medication, heat, braces or casts, physical therapy, and exercises, in that order. They tended to use surgery, physical therapy, and braces with the more disabled patients. Chiropractors used manipulation, heat, braces or casts, and exercises. With the more disabled patients, they were more likely to use heat and braces. Chiropractors used medication for only about 5% of their patients.

The patients were specifically asked about their sense of satisfaction with their therapist and his treatment (table VI). There was a statistically significant difference in the chiropractor patients' perception of the degree to which they were made to feel welcome. The chiropractors' patients were also significantly more satisfied with the explanation they received about their problem and its treatment.

DISCUSSION

Given the emotional climate of the medical community toward chiropractors, a dispassionate discussion of M.D. and chiropractic effectiveness is diffi-

TABLE VI—MEASURES OF PATIENT SATISFACTION

Measure	M.D. patients		D.C. patients	
	Satisfied	Dissatisfied	Satisfied	Dissatisfied
Ability of practitioner to return patient to previous functional level	101 (*91·7%*)	9 (*8·3%*)	115 (*94·0%*)	7 (*6·0%*)
Ability of practitioner to make patient feel welcome*	103 (*93·5%*)	7 (*6·5%*)	122 (*100%*)	0
Ability of practitioner to gain confidence of patient	105 (*95·4%*)	5 (*4·6%*)	116 (94·8%)	6 (*5·2%*)
Ability of practitioner to explain problem and treatment*	93 (*84·3%*)	17 (*15·7%*)	116 (*94·8%*)	6 (*5·2%*)

* Differences between M.D. and D.C. patients significant at $p < 0·05$ by chi-square.

cult at best. When a medical-care journal recently presented an article reviewing the experience of New York's Medicaid program in reimbursing chiropractors for their services,[7] a flurry of criticism and explanation ensued.[8,9] This study compares the care given by chiropractors and physicians in terms of the outcomes achieved for 232 similarly disabled patients.

There are, however, several limitations on the study. The design is retrospective; it relies on the patient's recall of his functional status at several points in time over the previous year. Although there is no reason to suspect any systematic bias to favour one type of provider over another, this possibility must be considered. Because chiropractors utilise a diagnostic nomenclature different from physicians, it was not possible to pair individual cases to assure their comparability. There is some suggestion, moreover, that those patients with more severe disabilities tended to consult physicians in preference to chiropractors. In the same vein, the pattern of a lower number of physician visits by patients failing to improve (table v) can be accounted for by assuming that patients failing to respond quickly tended to discontinue therapy before a beneficial result could be achieved. Finally, the number of patients examined is small. Significant medical problems which were remediable only by surgical intervention could have been missed just on the basis of sample size.

None the less, the results suggest that by two measures of outcome—patient's perception of improvement in functional status and patient satisfaction—the chiropractors have been as effective with the patients they treated as were the physicians. This may be in part attributable to good self-selection by the patient in his choice of therapist.

Moreover, it cannot be assumed that patients who choose to utilise a chiropractor are more likely to suffer psychosomatic problems. At least from the data obtained in this study, there was no difference in the hypochondria scores of chiropractor and physician patients. Nor can we attribute the use of a chiropractor to feelings of distrust or animosity toward physicians, for the data suggest no difference in attitudes between the two groups of patients. The selection of chiropractors by their patients seems to be based on other values and, at least from the patient's perspective, seems to have been successful. The chiropractors generated more patient satisfaction than did the physicians, particularly in regard to the patient's response to the personality of the practitioner and his ability to explain the problem and its treatment.

It is not our purpose to debate the proposition that chiropractic is or is not a legitimate method of therapy. Certainly the articles in the medical literature challenging its scientific basis and its academic credentials cannot be refuted by a single small retrospective study. Rather, we would suggest that there are valuable lessons which the medical profession might learn. These are mainly in the area of medical techniques for communicating with patients.

On the basis of our study and others,[10-18] it appears that the chiropractor may be more attuned to the total needs of the patient than is his medical counterpart. The chiropractor does not seem hurried. He uses language patients can understand. He gives them sympathy, and he is patient with them. He does not take a superior attitude toward them. In summary, it is an egalitarian relationship rather than a superordinate/subordinate relationship. Entralgo claims the major variables that explain why some patients prefer chiropractors can be found in the socioemotional aspects of the patient's relationship with his doctor.[13] Balint describes the most important element in all remedies as an emotionally satisfactory relationship between the invalid and his doctor.[14] Other workers have indicated the importance of the doctor-patient relationship to achieve effective therapy, especially in improved patient compliance.[15-17]

CONCLUSIONS

The facts revealed in this study underscore the powerful potential for the doctor–patient relationship in effective treatment, whether in chiropractic or traditional medicine. This factor should be recognised and accepted as an essential part of that process.

This study suggests that, although the theoretical basis of chiropractic is still unsubstantiated by traditional scientific evidence, none the less the intervention of a chiropractor in problems around neck and spine injuries was at least as effective as that of a physician, in terms of restoring the patient's function and satisfying the patient. Such a study illustrates the difficulties of measuring, or even defining, good-quality care. It may well be that any practitioner, regardless of his discipline, who is responsive to the emotional needs of the patient could achieve equal results; this is beyond the scope of the research described here.

We suggest that the results of this study indicate a need for further research, preferably in the form of a randomised clinical trial, to establish the validity of chiropractic care. As the storm clouds darken in the clash between organised medicine and chiropractic, it is imperative that definitive data replace impassioned statements. Perhaps the new regulations proposed under PL 92–603 will provide the means to conduct such studies.

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REFERENCES

1. Kuby, A. M. Master's thesis, University of Chicago, 1965
2. Ballantine, H. T., Jr. *New Engl. J. Med.* 1972, **286**, 237
3. Crelin, E. S. *Am. Sci.* 1973, **61**, 574
4. Bush, J. W. *Am. J. publ. Hlth*, 1971, **61**, 2362
5. Hulka, B. S., Zyzanski, S. J., Cassel, J. C., Thompson, S. J. *Med. Care*, 1970, **8**, 429
6. Pilowsky, I. *Br. J. Psychiat.* 1967, **113**, 89
7. Dintenfass, J. *Med. Care*, 1973, **11**, 40
8. Myers, B. A., Badgley, R. F., Sabatier, J. A., Jr. *ibid.* p. 436
9. Beilin, L. E. *ibid.* p. 441
10. Stanford Research Institute. Chiropractic in California. Los Angeles, 1960
11. Koos, E. *in* Patients, Physicians, and Illness (edited by E. G. Jaco), p. 113. Glencoe, 1958
12. Cobb, B. *Psychol. Bull.* 1954, **3**, 330
13. Entralgo, P. L. Doctor and Patient. New York, 1969
14. Balint, M. Doctor, Patient, and Illness. New York, 1957
15. Kane, R. L., Deuschle, K. W. *Med. Care*, 1967, **5**, 260
16. Francis, V., Korsch, B. M., Morris, M. J. *New Engl. J. Med.* 1969, **280**, 535
17. Bloom, S. W. The Doctor and His Patient. New York, 1965

AMERICAN CHIROPRACTIC ASSOCIATION

March 26, 1980

Hon. Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific
  Research
Senate Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The American Chiropractic Association would be grateful to you for including the enclosed statement on S. 2375 in the record of your hearing on that bill.

The comments in the statement deal with the failure of the HEW to include Chiropractic in the National Health Service Corps and the resultant discrimination against especially senior citizens in health manpower shortage areas.

Respectfully yours,

Harry N Rosenfield

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HNR:el

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HERMAN E. OLSEN, D.C.
President
AMERICAN CHIROPRACTIC ASSOCIATION

Statement on S. 2375

Submitted to

Health Subcommittee
Senate Committee on Labor and Human Resources

March 25, 1980

The American Chiropractic Association, the largest chiropractic professional organization in the United States, requests this Committee to rectify certain unfortunate aspects of the current operation of the National Health Service Corps which are detrimental to the best interests of the American people.

This program, conceived some 9 years ago, is a valuable vehicle for providing health care services to millions of Americans who otherwise would not easily be able to secure such health services in their home areas. According to the testimony of Surgeon General Julius B. Richmond, HEW's Assistant Secretary for Health, testified before Congress this past January that there are "746,000 people who today rely on Corps personnel for their continuing health care, people who 9 years ago had no regular doctor." Today there are 1,400 health personnel "on duty in remote rural areas, in small cities, and in poor urban communities where doctors have not chosen to serve voluntarily." He said that this program was authorized to operate in 1700 areas of the United States.

The Problem

HEW refuses to include doctors of chiropractic in the National Health Service Corps although it is authorized by the present law to do so. HEW's unjustified refusal is discriminatory against the millions of Americans who wish to have chiropractic health care. HEW's action is also inconsistent with the purpose of the program which Dr. Richmond described as "providing health services for populations who lack them." This obstructive Federal action is incomprehensible to communities who have sought chiropractic care under this program and have been rebuffed by HEW.

The present law authorizes HEW to

> "...conduct at schools of medicine, osteopathy, dentistry, and as appropriate, nursing and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps and the Scholarship Program," 42 U.S.C. Section 254d(b). (Underlining supplied)

HEW Frustrates Congressional Intent

The Congress has repeatedly made it clear that chiropractic health care is, and will continue to be, an established part of the health services rendered under the Medicare program. In total disregard of this Congressional intention, HEW refuses to provide chiropractic services for senior citizens living in health manpower shortage areas. Such deliberate disregard for Congressional intention is all the more indefensible since Surgeon General Richmond told a Congressional committee this past January that

> "The data show that shortage areas generally are characterized by high poverty levels, a high percentage of elderly, and infant mortality rates." (Underlining supplied)

Thus, although the Congress has specified that chiropractic health service is a key service to the elderly under Medicare, HEW thwarts this Congressional mandate by refusing to use its authority to make chiropractic Corpsmen available to senior citizens in health manpower shortage areas.

It is unnecessary to discuss here the nature and value of chiropractic health services, since the Congress - by recent actions - is fully aware of them. However, it is important that in carrying out the intent of Congress, HEW should not be allowed to thumb its nose at Congress by an arbitrary action in refusing to include chiropractors and chiropractic students in the National Health Service Corps.

The Remedy

The American Chiropractic Association respectfully suggests that there are two ways in which this unfortunate situation can be rectified, in the public interest. First would be to amend S. 2375 so as to include chiropractic specifically in Section 254d(b) quoted above.

A second alternative would arise if this Committee feels that such amendment is not necessary because the authority is already provided in current law. Then this Committee could do what a Conference

Committee did in connection with H.R. 3892, which became PL 96-151, where the original Senate version would have provided out-patient chiropractic care for veterans. There the Conference Committee determined that current law already authorizes such chiropractic health service without amendment and therefore directed the VA to exercise such authority accordingly. The Conference Committee said as follows in its report on H.R. 3892:

> "It is the understanding of both Committees that the VA generally has authority, which it has to date chosen not to use, to provide chiropractic services directly through chiropractors whom it may employ, as part of hospital care as defined in section 601(5)(A)(i) of title 38 and medical services as defined in section 601(6) to any veteran eligible to receive such care or services who is in need of chiropractic services, and to provide such chiropractic services on a contract basis under the general criteria prescribed in section 601(4)(C) for the provision of care and treatment on a contract basis...[B]oth Committees disagree with the VA's position that it should refuse to provide chiropractic services to veterans in every case and believe that chiropractic services for the treatment of musculoskeletal conditions of the spine may be beneficial and necessary in some cases. Therefore, the Committees urge the VA's Department of Medicine and Surgery to reevaluate its position and to use its existing authorities to provide, at least on a pilot basis, chiropractic services in appropriate cases as part of the hospital care or medical services furnished to veterans."

In another instance, the Congress went further and legislatively mandated the inclusion of chiropractic health services for Americans living in medically underserved areas, under the

Federal Employees Health Benefits Program, PL 93-368. Would it not seem odd for one group of our citizens, the Federal employees, to be granted the mandatory right to obtain chiropractic health services in medically underserved areas while the general public would be denied equal rights in health manpower shortage areas? We believe that such discrimination was never the intention of the Congress.

Recommendations

The American Chiropractic Association respectfully recommends that this Committee either amend the law as we have outlined, or include in its report on S. 2395, or any other relevant bill, a mandate to the HEW that it shall hereafter include qualified doctors of chiropractic and chiropractic students in its National Health Service Corps Program both as Corpsmen and as scholarship recipients, on a basis equal with other health professions already included in the program. We also recommend that, in order to do this effectively, the Committee direct HEW to amend its present descriptive bulletins and applications accordingly. For example, the application form now used lists 24 "services offered or proposed" but ignores chiropractic health services. This change would need to be made if the public is to be able meaningful to take advantage of the Committee's mandate to HEW. Similar changes of other descriptive material would also be necessary.

The American Chiropractic Association appreciate the opportunity to call this matter to your attention. We believe that the

Committee can importantly improve the effectiveness of the National Health Service Corps by enabling people in areas of health manpower shortage to choose chiropractic corpsmen or scholarship holders.

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